THE BRISTOL

Medico-Chirurgical Journal.

DECEMBER, 1886.

PRESIDENTIAL ADDRESS.

Delivered before the Bristol Medico-Chirurgical Society,

SESSION 1886-7.

BY

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GENTLEMEN,

Before proceeding to give you the few thoughts which have occurred to me as suitable to the present occasion, I must tender you my best thanks for electing me to this honourable position. As I told you, last October, I felt considerable diffidence in accepting the proffered honour; so now I feel not a little disturbed at the prospect of following so many distinguished friends who have so ably filled this chair. I can make no pretension to emulate them in their learned addresses; but I can assure you that it will be my earnest endeavour to discharge the duties of the office to the best of my ability, with due regard to its dignity and efficiency;

and I feel that in this endeavour I shall be supported by your sympathy and forbearance for the shortcomings of a man who makes no pretension to superior wisdom or knowledge, but simply aims at doing his duty with the feeble powers that God has endowed him.

I purpose occupying your time very briefly by a few remarks on the progress of practical surgery during my professional career. It is now nearly thirty years, since being qualified, I have been engaged in hospital work; and although it has fallen to my lot to perform many hundreds of operations, I regret to say that I have no continuous record of my work: and the only excuse I can make for this grievous loss is the usual one, of want of time; for I have always found that each day in a busy life brings with it its own work, and notes which have been put off for a more convenient season have never been accomplished. On this account, I have no data to fall back upon for any special subject.

It has often been said, and I think with reason, that much of the improvement in modern surgery is due to the increase of specialisms; and also, I would add, in great measure by the influence of societies, such as our Medico-Chirurgical Society, in diffusing the knowledge acquired by the research and practice of such specialists. Now, when I come to think what vast strides practical surgery has made during my recollection, I feel considerable embarrassment as to what points I should direct your attention.

It seems to me that in the first place we must look to anæsthetics as the starting point of all the improvements in operative surgery. There are, doubtless, some of my hearers present who remember the horrors of the operating theatre in the pre-anæsthetic period. I have a lively

recollection of it myself; for, as a schoolboy, my father used to take me to many of his operations—in order, I suppose, to give me a taste for my future profession; and I must confess that I think it had that effect, for I have always been more at home with the practical work rather than with the theoretical. At that time, brilliancy and speed were the great aims of the surgeon, in order to get his patient over the painful ordeal with as much dispatch as possible. Now all that is changed, and we are able deliberately to carry out our plans, with greater precision and more accuracy, without inflicting any pain. And here I would lay special claim to the value of chloroform, notwithstanding the way in which it is attempted to be discredited (especially in the pages of the *British Medical Journal*), some people going so far as to say that a surgeon using it ought to be indicted for manslaughter in case of fatal result. I maintain that it is the best and safest anæsthetic we possess, when carefully administered, and this by the simplest face-piece, with sponge in the centre, such as I have always used. Of course, we cannot forget that there is a certain amount of risk attending its use, by its supposed inhibitory effect on the nervous centres of the heart; but this is far outbalanced, in my opinion, by the blessings to the patient, for which the risk is worth incurring. We all know how in prolonged operations there is often considerable shock attending its administration; but then we must consider how many patients formerly died from shock alone, and some even from fear before the operation. I have known puerperal cases under its influence for fourteen and sixteen hours without any ill effect whatever. Æther is looked upon by many as the only safe anæsthetic. I differ from them. I remember the day when chloroform took its place, and with what joy

æther was discarded, with all the cumbersome apparatus necessary for its administration, the disagreeable taste attending its use permeating the breath for hours. Its more speedy effect in producing anæsthesia, and the facility of its administration, have been the reasons why chloroform has held its ground so long. I have never used any other compound, excepting nitrous oxide gas at the dentist's; and, personally, I have never had cause to regret my choice.

I should say that the development of hæmostatics was the next cause for the great advance in practical surgery. In my early days, silk ligatures were solely employed to tie the vessels, ulceration of the artery and suppuration in the deep parts of the wound being the necessary consequence of their removal, thus materially retarding the healing process. Torsion was introduced with great advantage. Then acupressure came into vogue: this was put aside altogether when research brought us the catgut ligature, which has now been so perfected that nothing better can be desired than chromicized catgut and Spencer Wells' forceps for staying all bleeding in wounds. In this connection I must refer to Esmarch's bandage and tourniquet, by which what is called the bloodless method of operating has been such a boon. It facilitates the exploration of diseased joints, and saves much loss of blood in the removal of sequestra from necrosed bones; and no doubt it has considerably reduced the mortality in amputations. It is true that objection is sometimes made to its use, from the amount of oozing consequent upon its removal; but this inconvenience can be remedied by first tying all visible vessels, then elevating the stump, and by using pressure with pad and bandage.

Then I would say that the antiseptic system of Sir J. Lister has done more in advancing surgical science than anything else. What untold advantages have followed its use in mitigating the sufferings and risks of operations! How rarely do we now see erysipelas, or hospital gangrene, which used to be the bane of our surgical wards—in many cases leading to the suggestion and use of separate houses, and even tents, for the better treatment of operation cases! The system so ably invented and perfected by Sir Joseph Lister leaves nothing to be desired. Faith in his system has led to the impunity with which the peritoneal cavity can now be dealt with; and the vast strides made in abdominal surgery are the outcome of this system. And yet many surgeons have now discarded the use of carbolic spray. Mr. Lawson Tait goes so far as to say that he would dress his wounds with pads of germs if he could collect a sufficiency for the purpose; and he tells us that he washes out the peritoneal cavity with ordinary company's water teeming with animalculæ. This seems rather heroic language; and one would be inclined to say that there is some truth in the old adage, "Familiarity breeds contempt." And yet what marvellous results he obtains! I remember at one time I came to the determination never to operate again on cases of cancer of the breast with secondary infiltration of the axillary glands, because I had lost a patient from septicæmia following this operation: but when I became familiar with the Listerian system, my fears were dispelled; and now I do not hesitate to recommend the operation, but advocate it most strongly—feeling secure in the preservative action of carbolic acid, and the good effects of perfect drainage, as the sure means of prolonging life in this dire disease.

I saw a patient last month for whom I removed a

very bad scirrhus of the breast, with infiltrated axillary glands, *some six years ago;* and she is now in perfect health, with a clean cicatrix. And this is only one of many who have had their lives prolonged by timely removal of the disease. Doubtless you are all familiar with many such cases. One can hardly realise what great triumphs have been brought about by all these modern improvements. In reflecting, I have often been struck by the fact that amputations are not so numerous as they were formerly; and this is due, I believe, to the teaching of such men as Mr. Hilton, in his lectures on the Influence of Rest, and Sir Wm. Ferguson, who did so much, in those so-called days of conservative surgery, in advancing the treatment of joint disease. In those days, nearly every joint in the body was excised, thereby saving limbs which before were sacrificed; but since the introduction of antiseptics, and the confidence given to us by the almost certain absence of risk of inflammation in opening joints under the spray, we have found that incision, with clearing out of *débris* and diseased membranes, together with drainage and proper care, has taken the place of excision, which is now almost as rare an operation as amputation. And we are not only able to save the limbs, but in many cases to ensure a movable and useful joint, where formerly anchylosis was looked upon as the most favourable result. Then, again, who can doubt but that operations are far more numerous than they used to be? And things are now accomplished which would not have been attempted by our forefathers. Look, for instance, to what perfection abdominal surgery is brought: kidneys, spleen, entire uterus and its appendages, are removed—the latter being frequently removed with impunity and advantage to many sufferers; explora-

tions of liver and gall bladder. Then, again, have not the larynx and œsophagus and large tracts of intestine been removed with safety? And ovariotomy—to what perfection that has been brought by the untiring energy of research!

Mr. Erichsen, in his address at Brighton, says there is no doubt we have reached finality in the mere mechanical art of surgery, both as to the expansion of its limits and the precision of its practice; but that we are yet on the threshold of the science of surgery: and so far as the treatment of wounds is concerned, almost absolute precision of result has been reached by the employment of strict hygienic precautions, and the adoption of the antiseptic method. The surgeon has thus arrived at this point of perfection—that he can assure his patient that there will be no suffering during the operation, as this is guarded against by anæsthetics; and no pain afterwards, for that can be averted by antiseptic dressings. We now know that the wound itself is not painful, but that after-pain is the direct result of septic inflammation: if this be prevented, and if healing by direct union be obtained —as it may be with almost absolute certainty under the improved dressings—no after-pain will result.

We see surgical science advancing every day. You have only to look at the report of cases by Mr. Victor Horsley, in last week's *Journal*, as evidence of the great advance in brain surgery, owing to the precision of diagnosis following in the path of researches on the localisation of cerebral disease by Ferrier and others. And it is due to antiseptics, aided by the skill of the operator, that such marvellous results can be obtained; for no surgeon would dare to cut away portions of the brain without faith in the preservative effect of such

agents. What may be in store for the future generations by the use of electricity, no one can tell. Already it helps us: by its lighting power, as in its adaptation to the ophthalmoscope and other instruments for examining the cavities; by its heat, in the electric cautery, and by its chemical or disintegrating power on the blood and tissues; by electrolysis, in dispersing nævi and other tumours; and also in the treatment of strictures.

I must now bring these remarks to a close, and apologise to you for the very discursive and crude manner in which I have brought them to your notice.

THE TREATMENT OF EMPYEMA BY INCISION AND DRAINAGE, AS ILLUSTRATED BY FORTY CASES.

BY

DR. NEWNHAM,

House Surgeon Bristol General Hospital.

My chief object in bringing forward such a hackneyed subject, is to emphasise the necessity of free drainage in these cases. In my humble opinion, aspiration should only be used as a means of preliminary diagnosis; for I feel very doubtful if we could effect a complete cure by it alone. Also I would raise the point, "Is it necessary to excise a portion of rib or ribs?"—a practice which is universally adopted at some hospitals now. My present idea, from the results of the cases I am quoting from, would lead me to say that I believe it is not necessary, and I think it adds somewhat to the severity of the operation: still, this is only my opinion; and it has been maintained that in children it is a necessity. In thirty-nine cases occurring in young subjects under the age of twelve years, it was not found necessary to remove any portion of any rib. I was always able to insert my tube between the ribs, and the statistics themselves prove that the results are as favourable as anyone could possibly expect to get.

Why is it that we meet with such a large number of cases of empyema amongst the children of the poor,

while it is such a very rare affection in those of the wealthy classes? I would suggest that they are simply untreated cases of pleurisy, to begin with; and the children being allowed to run about, being badly fed, and living in a bad atmosphere, the fibrino-serous effusion thus has a tendency to become purulent: such cases amongst the wealthier classes, on the other hand, under proper treatment, would probably remain simple effusions, and finally clear up altogether. So, if we state the matter broadly, we can say that it is all accounted for by bad hygienic conditions; for we know that an effusion is never purulent at the commencement, but always fibrino-serous—this has been experimentally proved.

At one time it was asserted that empyema never occurred in children under the age of six years. Ziemssen was one of the first to refute this; for he collected statistics of his younger cases, and showed that seventeen out of fifty-four occurred under six years of age, but of my *forty* cases *thirty-six* have been in children under six years. The reason for this statement is obvious: the medical attendant often fails to examine the chest of a child; whereas, if he would only look at the case from the same point of view as he would his adult patient, he would find no difficulty at all, and we should be spared such very rash statements.

Another question that may occur to us is, "How is it that such enormous quantities of pus are again and again effused?" May it be that a rapid process of cell division amongst the colourless cells, which have wandered out of their vessels and are present in the fibrino-serous effusion, takes place, and so an exudation which was at first fibrino-serous becomes purulent?

The tube which I have used consists of an ordinary

piece of drainage tube threaded through a circle of Martin's bandage, then divided into four pieces and tacked down with wire at four separate spots. I do not claim any originality for it; but I think it is very simple, easily made, and accessible to all.

The case on which I founded my paper was a boy, aged eleven years, admitted into the Bristol General Hospital on January 15th, 1886, under the care of Mr. Keall. The right chest was full of pus, and three days after admission the chest was incised in the eighth space, with all antiseptic precautions, and the tube introduced. As usual, a very large quantity of thick curdy pus escaped, which it would have been utterly impossible to get out by means of an aspiration. This boy did remarkably well: the antiseptic dressings were changed daily at first, and the tube taken out, washed and replaced; and on February 8th (twenty-one days after the operation) the tube was left out altogether, and a week subsequently the boy was discharged cured. The tube had to be kept in the chest rather longer that in some of my cases; but this boy had been ill for three weeks before he was seen by a medical man. I venture to think that if we could only get the cases under treatment sooner, our results would be still better.

Of the forty cases of empyema I have treated myself, one died; this was a child of five years old, admitted too late for any treatment to be of use, for the pus had perforated the diaphragm and set up peritonitis. Thirty-six were discharged from the hospital quite well: four of these healed fourteen days after the operation, and the other thirty-two at variable times, not exceeding eight weeks. Three were sent out with a small sinus still left; there was a very small amount

of discharge, and they had been under treatment for eight weeks.

The statistics of these cases have been already published by Dr. Goodhart, in his work on *The Diseases of Children*. They all occurred at the Evelina Hospital for Sick Children.

In the last nine months we have had four cases, in which I have incised the chest for empyema:

1. A child under the care of Dr. Baron. Here the result was perfect; it was well and left the hospital four weeks after the operation.

2. A girl, aged 24, also under the care of Dr. Baron. Now, this case had been aspirated three times at the Infirmary, and she came on to the Hospital, as patients often do; they try first one place and then another. On the day of her admission I incised the chest, let out about ten ounces of pus; and in ten days I was able to take out the tube, and the wound healed up within a week.

3. A girl, aged 22, under the care of Dr. Markham Skerritt. She was admitted with the left chest full of pus, the heart's apex being felt just under the right nipple. In this case also the chest was incised directly, and although the patient was almost moribund, she made a good recovery. The wound quite healed, and she left the hospital in six weeks after the operation.

4. A man, aged 26, with the left chest full of pus. This is still under treatment, having only been operated on a week ago.

I may say here, that I never wash the chest out, or syringe any lotion into it of any kind or description, and for this reason: cases have occurred in which the patient has suddenly fallen back in bed and died. Therefore, I

think it is a very dangerous practice; and I also believe, from my small experience, it is quite unnecessary.

An argument is occasionally brought forward by some surgeons, that in the adult you will *always* have a sinus left. My answer to this would be, that if the case is taken sufficiently early and treated properly, the operator will never have cause to regret it, and he will never get a sinus left; out of forty-five now, I have had only three with a sinus, and it is only fair to assume that as they did not appear again, those cases also must have healed.

I will now quote one or two cases more in detail:

1. G. H., girl aged 4½ years. Admitted August 4th, 1884, to the Evelina Hospital. Left chest dull from apex to base; breath sounds distant all over, but not absent at any one point. Circumference of chest showed the right to be nine inches, and the left nine and a half inches. T. 98.6, P. 120. Incised the same day; large tube inserted after the pus had escaped. Dressed with all antiseptic precautions. The wound had healed, and the child was quite well on August 26th, or *twenty-two* days after the operation.

2. F. D., boy aged 4 years. Admitted on August 31st, 1884. Right chest full of pus; patient very livid and breathless. T. 98.4, P. 140. As the father objected to the boy taking chloroform, I did the operation as quickly as I could without. The case did well; the wound closed, and the boy was discharged on October 2nd, or *thirty-three* days after the operation.

3. M. R., girl aged 4 years. Admitted with the left chest full of pus. Operated on the same day, January 3rd, 1885; fifteen ounces of pus escaped. Dressed in exactly the same way as all the others, and on January

17th, or *fourteen* days after the operation, the wound had quite healed.

4. L. L., girl aged 4½ years. Right chest full of pus. Sent to me by a medical man, who requested me for charity to give the child a place to die in. The operation was done the same day; over forty ounces of pus were measured. This case also did well; but the wound had not quite healed until the forty-sixth day after the operation.

5. E. J., girl aged 6 years. Left chest full of pus. Wound had quite healed thirty days after the operation.

6. H. H., a boy aged 7 years. Empyema on right side. In this case I tried a free incision, without inserting any tube. As may be imagined, it was not a success; the wound closed on the surface, and two days later I had to re-open it and put in a drainage tube. The boy was not well until the thirty-fourth day after the operation.

It would be of little interest for me thus to quote the whole forty cases; I will merely mention the fact, that I could give some of the results of repeated aspirations which it has been my misfortune to meet with, but I will refrain.

Clinical Records.

CASE OF PERNICIOUS ANÆMIA. By THOMAS COLE, M.D. Lond., M.R.C.P., Physician to the Royal United Hospital, Bath.

W. B., a cabman, æt. 35, was admitted into the Royal United Hospital, Bath, on June 21st, 1886.

He had always lived in England. He had acute rheumatism seven years ago. His health had failed since January—dyspnœa, nocturnal cough, and anorexia being the prominent symptoms. He was extremely pale, and had a troublesome hacking cough, with very short breath on exertion. There was dulness at the right apex, with defective respiratory murmur and crepitation. There was a double cardiac bruit audible at base and apex, and loudest over the sternum. The liver and spleen were much enlarged. The feet and legs were œdematous. The urine contained no albumen, and its density was normal. His pulse was 96. The temperature was invariably pyrexial in the evening for a considerable period, but gradually became normal. There were numerous variously shaped retinal hæmorrhages, mostly striate, and radiating from the optic discs. The red blood-cells averaged about 940,000 per cubic mm. of blood, and the white about 7500. He expectorated some blood-stained sputum. He was placed upon tartrate of iron, cream of tartar, and digitalis. Under this treatment the œdema

subsided, and the general health improved. But the liver and spleen increased in size, and the pallor was extreme. He also had some epistaxis. On July 5th there was a trace of albumen in the urine. On June 28th he was put upon hydrochloric acid, sulphate of iron grs. ii., and liq. arsen. hydrochlor. ♏ iii. ter die. The quantity of arsenic was gradually increased till, on August 2nd, a dose of ♏ xii. t.d. was attained. On July 19th the spleen had subsided, and the liver was smaller. On the 26th the red blood-cells had increased to 1,780,000 per cub. mm. On August 3rd the weight was 10 st. 2 lbs., the cough had gone, the lung trouble seemed obsolete, and the œdema had almost disappeared. Once only was there a trace of albumen. On August 7th he was discharged, fairly well. He lately presented himself at the hospital in good health, all the morbid symptoms having ceased.

That this was a case of pernicious anæmia cannot be doubted. It is not the first case which I have seen recover. There is a ring of despair about the word "pernicious" which, however useful as indicative of the serious nature of the malady, may be injurious by inducing a hopeless attitude in the practitioner's mind, by no means conducive to a patient and persistent attack on so powerful an enemy. The symptomatology of this disease is certainly suggestive of some species of blood-infection, and very possibly an external influence may one day be detected as its cause. Perhaps this may be the reason why arsenic is so useful in this and other forms of anæmia. Be this as it may, it was unquestionably most valuable in the case in question; and I should, without hesitation, recommend the administration of much larger doses of the drug, if necessary, in any similar cases.

CASE OF ANEURISM OF AORTA—TREATMENT BY GALVANO-PUNCTURES: RESULT ENCOURAGING.

By R. SHINGLETON SMITH, M.D., F.R.C.P., Physician to the Bristol Royal Infirmary.

Susan S., æt. 29; married ten years; two children—one of them still-born, the other died at seven months; one miscarriage. No definite history of syphilis, beyond falling of hair and occasional sore throat. Had typhoid fever ten years previously, and rheumatic fever fourteen years ago. No history of intemperance.

Was first admitted to Bristol Royal Infirmary on November 4th, 1882, complaining of pain in right side of chest, dyspnœa, dysphagia, and other symptoms suggestive of aneurism. The patient dated her symptoms from October, 1881; when, lifting something heavy, she felt as if "something suddenly snapped in her chest," and severe pain obliged her to desist from her occupation and lie down. A few days afterwards the pain diminished; but it had never since left her entirely. It had varied much in intensity and position, but became more and more constant. Her breathing became difficult, and there was some dysphagia. On admission, the pain was through the right side of chest, from the sternum to the shoulder, and down the right arm. It was increased on swallowing, and was so severe as to require hypodermic injections of morphia.

There was dulness at the right infra-clavicular region, extending to the fourth intercostal space; also at the supra-spinous and infra-spinous regions of the same side, as low as the middle of the scapula.

There was a slight systolic bruit in the second right interspace, and some little displacement of the heart's apex; but no definite tumour or abnormal pulsation could be made out.

The patient was put on Tufnell's diet, and treated with iodide of potassium, in doses increasing from 10 to 60 grains, three times daily.

January, 1883. There was little change. Occasional attacks of pain were present; but no increase of the symptoms.

June, 1883. The dysphagia had entirely passed off, and the pain had much diminished.

On July 19th she was made an out-patient, and then took ordinary diet.

October 23rd. Was re-admitted; and again made out-patient on January 29th, 1884.

October 28th, 1884. Patient had continued to attend as out-patient, and had taken the iodide of potassium in reduced doses. The symptoms had varied in intensity from time to time; but she had never been altogether free from pain: had often experienced difficulty in swallowing, and occasional spasmodic cough, with some bronchitis. About a week ago the pain had increased in severity, and she was again made in-patient.

At this time she had a careworn and anxious appearance, with eyes somewhat prominent, and veins on right side of neck distended. There was no evidence of defective nutrition, and the axillary temperature was normal on both sides. The left radial pulse was a little stronger than right. There was now distinct bulging at the upper part of the chest; and a diffused pulsation could be felt on the right of the sternum, at the second and third interspaces. The sternum was distinctly prominent—most

so at the level of the second interspace. No bruit could be heard over any part of the swelling. There was some displacement of the apex beat, and a systolic apex murmur.

The voice was a little husky, and there was frequent dry cough. Loud tracheal breathing was audible at the second right space near to the sternum, and behind at the right interscapular region, where there was also some percussion dulness. Patient was again put on a limited minimum diet, and iodide of potassium in doses of 40 grains.

November 24th, 1884. There was no material improvement, and the patient complained much of pain and dyspnœa: accordingly, it was resolved to employ the galvanic needles. No anæsthetic was given by inhalation, but cocaine was used locally. One needle was inserted at the second right interspace, and was kept in for twenty-five minutes; the negative pole being connected with a large sponge, which was held to the surface and varied in position. Patient did not complain much of pain at the time, but a few hours afterwards required a hypodermic injection of morphia. The day following, it was thought that the swelling had increased slightly, and the cough was very troublesome.

A second operation was performed on November 30th, when two needles were inserted, and retained for thirty-two minutes, with a current at first from twenty-five Leclanché cells, afterwards from twenty, and for the last ten minutes from only fifteen cells. No anæsthetic was used, locally or generally. Both needles were attached to the positive pole, and the negative pole was applied by means of a sponge to the surface of the tumour. The passage of the galvanic current appeared to give rise to

considerable pain at the sites of puncture; so much so, that the current was reduced in intensity, in order that it might be continued. This second operation was followed by distinct improvement: two days after, the pain had much abated, there was less dyspnœa, also less cough; and the patient believed that the swelling "did not heave so much." Ten days afterwards the improvement had continued, and the pulsation had distinctly diminished.

January 10th, 1885. There had been more pain in the arm and shoulder; and the patient, encouraged by the result of the previous operations, wished to continue the galvanic treatment. Accordingly, two needles were again inserted, cocaine having been previously injected at the site of each puncture. The needles gave rise to much pain whilst the current was passing; but it was continued, more or less steadily, for eighty minutes. Ten days later there was a little improvement, but no decided change in the condition of the swelling. The punctures had on each occasion healed without difficulty, but a little black blood had usually escaped when the needle was withdrawn.

January 31st. The sternum was decidedly more prominent than before; there had been more dyspnœa, and some duskiness of face. Patient was again anxious to have the needles, as she was satisfied they had previously given much relief. A fourth operation was performed on February 14th, two needles being introduced, one on either side of sternum, in the second intercostal space, and retained for one hour, with a current of twenty-five cells. No anæsthetic was used. The expansile pulsation of the sac was well demonstrated by the movement of the two needles, one on either side. On the following day the patient was very comfortable, and the heaving pulsation was less marked; but the skin at the punctures

appeared to be inflamed to an area of a quarter of an inch in diameter. The tracheal breath-sound, both in front and behind, was less marked. A fortnight later, March 1st, there was a definite improvement: the heaving impulse was slowly diminishing, and the prominence of sternum less marked; the pains were less frequent, and the breathing fairly easy. For about a month there was no indication for further interference; but, on consultation, it was agreed that more active galvanic treatment was justifiable, in the hope that it would do more than alleviate distressing symptoms. Accordingly, on May 13th, a fifth operation of a more energetic character was performed. It was intended that a larger number of insulated needles, all attached to the positive pole, should be passed into the sac; and this was scarcely possible without anæsthetic. On previous occasions it had been found that ether by inhalation gave rise to much excitement and dangerous struggling, and therefore anæsthesia was induced by means of chloroform. Four needles were introduced to a depth of two inches, two on the right and two on the left of the sternum; the bone, although softened, prominent, and pulsating, afforded a barrier which the needle would not pierce. A current from thirty cells was maintained for half an hour, the negative pole being in contact with the skin by means of a sponge rheophore, the position of which around the tumour was frequently varied. On removal of the needles, no bleeding took place from those on the right; but there was copious oozing of black fluid blood from those on the left, which was at last arrested by collodion pads and pressure. During this operation the patient was profoundly unconscious and cyanosed; the breathing had been much distressed, and the chloroform had been discontinued

after the first five minutes, because of cyanosis and other indications of asphyxia. The pulse continued regular, but small; and artificial respiration maintained the action of the heart, in spite of very deep cyanosis and venous engorgement. Unconsciousness continued from 12.40 to 3 p.m., when the breathing power returned, and artificial aid was discontinued. After return of consciousness there was no evidence of paralysis, or any indication of embolism. At 5 p.m., there being some complaint of pain, a small morphia draught was given, and the patient slept quietly for five hours.

On the following day the patient was of good colour, the cyanosis having disappeared; the breathing was easy; there was no dysphagia, or cough; and no pulsation could be detected by the hand on the tumour. Pulse 116, regular.

Two days later there was some cough, with purulent expectoration, and stridulous breathing, with a little return of cyanosis: on the day after, epistaxis, with laboured breathing, and decided pulsation in tumour.

One month after the fifth and the major operation, there had been very marked and steady improvement: there was no dyspnœa, no cyanosis; pulsation was less decided; and the aneurism felt firmer, as if more consolidated, although the area of dulness remained stationary.

On July 31st she was able to get up and move about. The tumour was not increasing, and there were no active symptoms. Accordingly, she was allowed to go home, and present herself from time to time as an out-patient. This she continued to do through the winter; but on April 26th, 1886, she was re-admitted in consequence of a very violent attack of general bronchial catarrh, which commenced four days before. There was much dyspnœa

and cyanosis, with cough and expectoration; but no œdema of legs, no hæmoptysis, and no increase of the aneurismal signs. The air entered both lungs equally, and the cough was not of spasmodic character; but there were loose râles on both sides. There was no decided pulsation in the aneurism; but the prominence and area of dulness were as before.

On the following day there was copious expectoration by the aid of an apomorphia mixture (gr. $\frac{1}{24}$) with hydrobromic acid and ether; but on the day after, the patient expired, four hours after an injection of one-third of a grain of morphia.

On examination after death, it was found that the upper portion of the sternum was pushed forward by a large aortic aneurism, adherent to the periosteum behind; the bone was very thin, as also were the coats of the sac. The aneurism involved the first and second parts of the arch; was as large as a child's head at birth; was soft and yielding, but pressing equally on the trachea, just above its bifurcation; on the bronchi, more especially the right, and the œsophagus; but neither tube was materially occluded or eroded.

The lungs were full of frothy mucus; there was much bronchial congestion, with œdema and partial consolidation at both bases.

On the visceral layer of the pericardium covering the aorta was a large patch of old inflammatory lymph (probably the result of the operative interference).

The aneurismal sac was opened from the front: it was firmly adherent to the sternum, which was sawn through longitudinally, and was nowhere entirely perforated. The cavity contained much soft *post-mortem* clot; but a laminated mass of old firm fibrine (one inch

and a half thick) occupied the anterior portion of the sac, was adherent to the wall, and may have been the result of the numerous operations. No laminated clot existed in any other part of the sac; and here it was exactly what one might expect to occur from the induction of coagulation in foci, by means of galvanic action. The walls of the sac were thin, but composed of all the arterial coats. The aneurism was sacculated; it grew from the right front wall of the aorta; its orifice was about three inches in diameter and seven in circumference. A secondary thin-walled sac bulged from the posterior wall of the main cavity. The lumen of the great vessels springing from the arch was not obstructed; nor were the veins compressed.

No marks of the galvano-punctures could be detected in the walls of the sac.

This case, watched continuously throughout a protracted course of nearly four years, and diagnosed from the onset as one of aneurism of aorta, derives its principal interest from the question of treatment. Iodide of potassium, in combination with rest and a limited diet, appeared to arrest the course of the disease: the symptoms abated, and the patient considered herself well enough to leave the hospital ward, and go to her own home, after nine months' treatment.

On being re-admitted three months after, the symptoms were again relieved; and she was discharged, fairly well, in a little over three months.

Nine months later, galvanic treatment was commenced: first with one needle introduced into the sac; then, a week later, with two needles, insulated except at the ends; five weeks later two needles; and after another interval of four weeks, two needles for the third time. There was

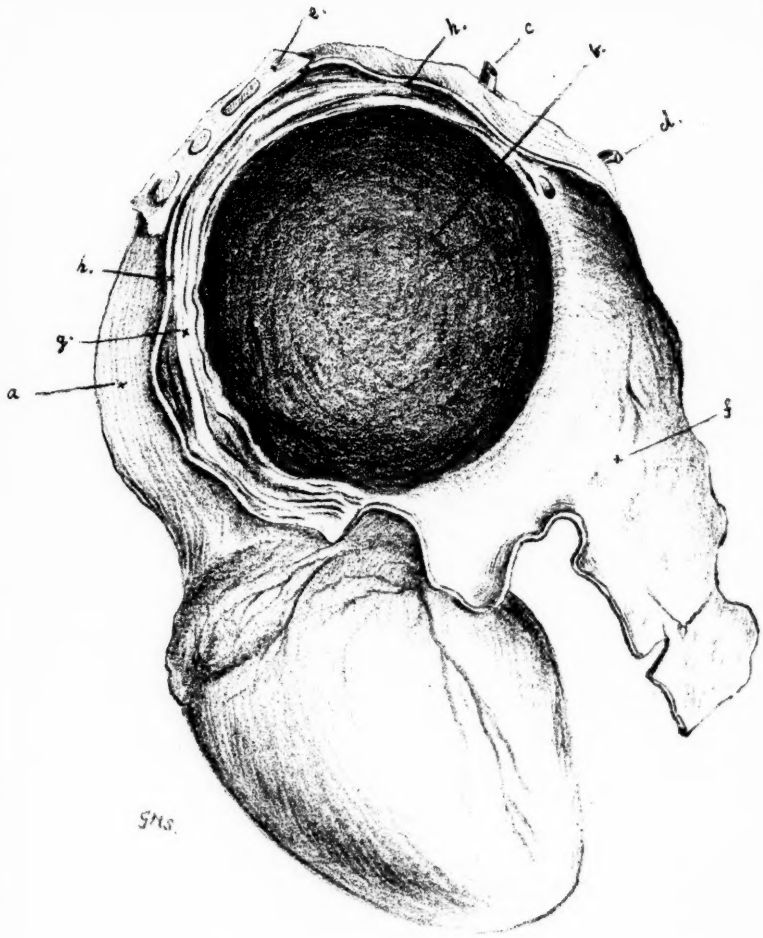

Fig 1.—

a. Outer wall of Aneurismal Sac.
b. Interior of Sac.
c. Left Carotid Artery.
d. Left Subclavian Artery.
e. Part of Sternum sawn through.
f. Interior of Aorta.
g. Laminated clot lining the Aneurism.
(N.B.—This has not been made thick enough in the Drawing).
h. Wall of Sac (cut edge).

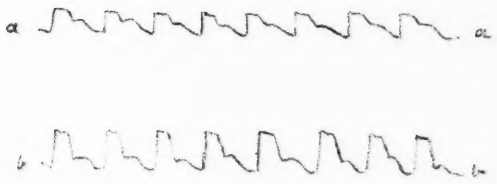

Fig 2.—a. Tracing of left Radial Pulse.
b. Ditto of right ,, ,,

then an interval of three months; but the patient would willingly have had earlier and more frequent operations, as she was convinced of the relief given by the previous ones. The fifth operation, apart from the question of anæsthesia, gave a very encouraging result, and certainly supports the view that galvano-puncture, in spite of much adverse criticism and experience, when carried out in a particular manner, is likely to be of benefit, even in so formidable a disease. Even now text-books advise that the needles should be connected with both poles of the battery; whereas it is well-known that firm coagulation takes place on the positive pole only, and gas is evolved at the negative needles, which must materially interfere with the formation of a firm clot inside the sac. There can, therefore, be no advantage in having the negative pole introduced through the skin; and, on the other hand, it must be an advantage to have a considerable number of needles, all connected with the positive pole, which may act as so many centres of coagulation, the clot around the various centres forming a large coherent mass, if the needles be sufficiently numerous and near to each other. In this case, the condition of peril of the patient soon after the commencement of anæsthetic, prevented the introduction of more than four needles at one time, and these must have been at a considerable distance from each other; nevertheless, the condition found after death appears to indicate that the various operations had induced some amount of coagulation in the part of the sac which the needles had reached. From the clinical point of view the benefit was decided; and the fact that the patient repeatedly wished and asked for further operative interference, is the best possible evidence of the relief afforded to symptoms from time to time.

After the last operation, the general health continued to be better than before for about twelve months; the question of further interference having been avoided, in consequence of the danger of anæsthesia, without which no such operation as is likely to be efficient would be practicable. Death took place at last from a severe attack of double catarrhal broncho-pneumonia—no doubt influenced by and aggravated by the aneurism; but, manifestly, not set up by or due to the aneurism itself.

It cannot be claimed that the aneurism was cured by galvano-puncture: its progress was, however, arrested; and the death of the patient arose from another disease, nearly five years after the first commencement of the symptoms, and nearly four years after the presence of aneurism of the arch had been recognised.

This case does, therefore, give encouragement to the further trial of a method of treatment which has hitherto been somewhat disappointing, but which may yet be productive of far more decided and more permanent benefit than has as yet been observed.

THE USE OF THE ASPIRATOR IN RETENTION OF URINE.

By W. FAIRBANKS, M.D. Edin., Wells.

In connection with the use of the aspirator, the following case presents some features of interest which seem to make it worth recording.

A. B., æt. 76, after suffering during several weeks from slight troubles of micturition, was on February 17th, 1886, seized with complete retention, and was relieved by

catheter. Similar relief was given on several occasions, but three days later difficulty arose in passing an instrument, and the assistance of a hospital surgeon was obtained to overcome it.

On the 22nd February, symptoms of bladder distension were urgent, and now the difficulty of reaching the urine by the urethra was insuperable. The aspirator was used at 9 p.m., February 22nd, for the first time. As I am recording the case simply for its bearing on the use of the aspirator, I shall not enter into it fully, but simply enumerate the operations which were performed after the case came under my own observation.

Feb. 22.	9.0 p.m.	Aspiration	Mar. 1.	9.30 a.m.	Aspiration
23.	4.0 p.m.	"		8.0 p.m.	"
	8.30 p.m.	"	2.	9.0 a.m.	"
24.	1.0 a.m.	"		8.15 p.m.	"
	8.30 a.m.	"	3.	9.45 a.m.	"
	2.30 p.m.	"		8.30 p.m.	"
	8.0 p.m.	"	4.	10.30 a.m.	Catheterism
25.	3.0 a.m.	"		11.50 p.m.	Aspiration
	10.0 a.m.	"	5.	12.15 p.m.	"
	5.0 p.m.	"	6.	12.15 a.m.	"
	11.50 p.m.	"		11.15 a.m.	"
26.	10.30 a.m.	"		9.30 p.m.	"
	8.30 p.m.	"	7.	1.0 p.m.	"
27.	9.30 a.m.	"	8.	1.0 a.m.	"
	7.30 p.m.	"		9.30 a.m.	"
28.	12.0 noon	"	11.	11.30 a.m.	"
	8.30 p.m.	"			

It will be seen that during fifteen consecutive days, the whole of the urine, with the exception of that drawn off on one occasion by catheter, was passed through the needle of the aspirator. Upon some occasions, when the

patient was more fully conscious, the skin was frozen before the puncture was made; but the pain caused by the needle was never greatly complained of, while the annoyance of the spray was not altogether trifling. From first to last the bladder was aspirated above the pubes thirty-two times. After the resumption of the catheterism on the 8th March, the aspirator was called for only once, and then by the want of prompt success with the catheter, and the dread of irritating the urethra just as it was becoming more tolerant of instrumentation.

The peculiar difficulties of the case were met by manœuvres familiar to most surgeons, and therefore needless to record; but it may be interesting to note two points: 1. It was probably due to the previous injection of a solution of cocaine that I was able to pass a No. 8 silver catheter on the 4th March. 2. A plan I found useful in a somewhat later stage of the case was as follows: A soft rubber catheter was passed down the urethra until it met with its check at or about the prostate. Then a long stylet, made for the purpose and shaped as desired, was passed within the catheter, which by its help was guided onwards into the bladder, with the minimum of irritation to the parts, and could be left in if desired.

Before passing on to consider the bearing of the case upon aspiration of the bladder, I may say that the patient gradually obtained control over his bladder, recovered, and is still (October) quite well. It is worth noting also, that when he had regained sufficient control to dispense with aid, and while the urine was ammoniacal and loaded with pus, it seemed, to all the surgeons who saw him, desirable to wash out the bladder from time to time. Nevertheless, as the proceeding was objectionable on many grounds, I first gave a trial to fluid extract of Corn

silk; and while full doses of this drug were being given, the urine gradually cleared up, and in eight or nine days was free from deposit and from offensive smell.

The successful issue of this case would seem to indicate that the relief of the bladder by aspiration through the abdominal wall is at once—

a. Easy.
b. Perfectly safe.
c. Capable of very frequent repetition.

a. *Easy*.—Truly, nothing is easier than to puncture the over-distended bladder in the ample space provided by its very distension. But in a case of this kind there comes a time when the viscus is less tolerant of its contents, the urine is alkaline and loaded with pus, and the patient, with only six or seven ounces in his bladder, calls loudly for relief. If, under such conditions, one should attempt to aspirate, it is quite possible that no urine would flow. The flaccid bladder is not so easily pierced, and may escape puncture. A bold and quick thrust in the right direction, however, will not fail; and immense relief follows the removal of six or seven ounces of purulent and bloody urine, and the washing out the bladder through the aspirator with Sir Henry Thompson's solution. It is granted that cases presenting such a combination of circumstances as to require this proceeding must be very rare.

b. *Perfectly safe*.—Thirty-two aspirations performed, with nothing but benefit accruing, suggest the harmlessness of the proceeding. And yet the evidence is anything but conclusive. Indeed, to my mind, a series of ten cases of three aspirations apiece would be more to the purpose. It is always possible that inflammation may arise at the

seat of the puncture, as in a case recorded by Dr. Macfie Campbell (*B. M. J.*, February, 1880), though such inflammation would seldom lead to similar disastrous consequences. Dr. Campbell, attributing the abscess in his case to extravasation of urine into the tissues, deduces the lesson that after aspiration the bladder should be kept undistended. In the case now recorded, the bladder was extremely distended before the second aspiration, and fully so on several subsequent occasions. Nevertheless, no urine escaped; nor can I think extravasation more than barely possible, if a moderately fine needle has been used. I can more easily conceive other causes for abscess at the seat of puncture. Though we may not go so far as to claim perfect safety for the operation, it is yet the safest and most suitable in this and in similar cases. Against tapping by the rectum there are objections: it cannot be repeated frequently; it is extremely difficult to keep a cannula in position, and very wretched for the patient if achieved. The elastic catheter of Mr. Davey (*B. M. J.*, December, 1875), though theoretically admirable, could not have been retained an hour in this case, owing to the restless and mischievous delirium of the patient.

c. Capable of frequent repetition.—Apart from the local skin-irritation produced, there seemed to be no limitation to the bladder's tolerance of aspiration. I find it stated that the aspirator may be used three or four times successively if a case demands it; but it seems probable that, if three or four aspirations are well borne, twelve or twenty may be practised without fear. No preconceived rules as to the frequency for its need should influence us. We should operate when the circumstances require it. Healthy kidneys may secrete with enormous rapidity after

an over-distended bladder has been relieved for the first time; but this rush soon subsides, and then twelve hours will not serve to distend the bladder so fully as four hours would do at first. Unless the patient dread the prick of the needle, it is doubtless better to avoid freezing the skin in cases likely to require frequent operation.

It may be concluded that the surgeon may undertake aspiration of a distended bladder above the pubes with as much freedom from anxiety as attends any of the minor operations. He may thus gain time to conceive and carry out any plan for the permanent relief of his patient; and he need never become flurried or desperate over the tightest stricture, the most obstinate spasm, or the least accommodating prostate.

Periscope of Medical and Surgical Progress.

NOTES ON SURGERY. By W. J. Penny, F.R.C.S., Assistant Surgeon to Bristol General Hospital.

Excision of the Laminæ of portions of the Spinal Vertebræ to relieve pressure on the Cord causing Paraplegia.—At the Glasgow Pathological and Clinical Society, Dr. MacEwen showed two cases of the above operation.

The first case was one in which the operation had been performed for paraplegia following very acute angular curvature in the dorsal region, and in which the parts had become firmly anchylosed. There was complete motor and sensory paralysis, with spastic contraction, and absence of reflex actions. The case looked hopeless, and only from urgent pressure was the operation performed. Dr. MacEwen described the operation which resulted in the restoration of the functions of the part. The patient was shown to the Society. She could move her lower limbs freely, and she had walked a quarter of a mile that night to the place of meeting. She had complete continence of urine and fæces from the fourth day after the operation.

The second case was one of fracture of the spine by direct violence, resulting in complete motor paralysis, with incontinence of urine and fæces. The fracture was in the lower dorsal region. (There was likewise a compound fracture of the tibia.) Over the lower dorsal region there was great tumescence from extravasation of blood, which obscured the exact condition of the laminæ and spinous processes. Three weeks after the injury the muscles had undergone rapid atrophy, with strong and increasing contractions, and there was no electric contractility. Towards the end of the fifth week, pressure points began to appear at various parts of the lower limbs, and the urine became thick and ammoniacal. The operation of elevating the laminæ was described. Two of the laminæ were found driven in on the spinal canal. The man was shown at the meeting. Nine months after operation able to walk, and move his feet and limbs freely. No incontinence

of urine or fæces remained.—*Glasgow Medical Journal*, March, 1886.

THE TREATMENT OF LUPUS.—Professor Trendelenberg, in describing this disease, fully accepts its tubercular origin, and advocates total destruction of the affected tissue. Various methods succeed, if each suspicious spot is included in the treatment, and the operation is repeated at the right time. Formerly internal remedies were much in vogue.

Professor Trendelenberg recommends caustics in the shape of pencils, but preferably the actual cautery in the convenient form of the pointed thermo-cautery. Volkmann advises removal of the disease with the sharp spoon. This plan, when followed by cauterisation with a Paquelin, is considered commendable. Lupus will heal out with washings of a solution of corrosive sublimate. Erysipelas has also had a favourable effect. In excision, with subsequent plastic covering, the flap is not safe from infection.—*Annals of Surgery*, August, 1886.

LAPAROTOMY IN THE TREATMENT OF STRANGULATED HERNIA.—The principle of opening the abdominal cavity near the seat of a strangulated hernia has lately attracted some notice. The operation has been suggested for some years past, by several surgeons, as a substitute for herniotomy. Professor Annandale, in a paper read before the Edinburgh Medico-Chirurgical Society in 1873, summarises his views as follows:

The principle of this method consists in making a small incision into the abdominal cavity near the hernia, instead of cutting into the hernial sac itself, or exposing it. One or more fingers are then to be inserted into the abdominal cavity, and the protruded structures contained in the hernial sac drawn back from within. The ease with which a strangulated portion of gut is relieved when gentle traction is made upon it from within is remarkable. He further says: "The cases which appear to me most suitable for the operation are:—

"1. Umbilical herniæ in the adult, especially if the coverings of the hernia are thin and ulcerated, or the hernia large.

"2. Large inguinal or scrotal herniæ, which have been recently reducible.

"3. Herniæ in other regions, in which, owing to special conditions, the usual operation cannot satisfactorily be performed."

Mr. Hurry Fenwick published a paper in the *Lancet* for

September 26th, 1886, entitled "Laparotomy as an Aid to Herniotomy." It was based on a case of strangulated left inguinal hernia, that could not be reduced after the sac had been opened and its neck incised. The obstruction was due to a piece of tensely-inflamed bowel, which was adherent to the margin of the internal ring. A two-inch median incision just above the pubes was therefore made, the forefinger introduced, and the entire hernia rapidly and easily withdrawn.

Mr. C. B. Keetley (*Annals of Surgery*, June, 1886), after stating that the guiding principle of his idea was laparotomy as an *aid* to herniotomy, summarises his views of the indications for laparotomy thus:—

1. When, in herniæ of any class, the constriction having been divided, very exceptional difficulty is met with in reducing the intestine. This indication more especially has force when hæmorrhage from the notch is persistent or severe. Putting aside this important consideration of the prevention of hæmorrhage into the abdominal cavity, this indication must be one of extreme rarity.

2. When the hernia has been quite recently strangulated, and belongs to one of two classes, namely:

a. Congenital hernia in the male;
b. Umbilical hernia. (?)

In the first class of cases it is to be done as an aid to, and in the second as a substitute for herniotomy.

Mr. Keetley protests against division of the stricture from the abdominal aspect.

If peritonitis were discovered at the operation, he suggests the washing out of the peritoneal cavity, and the introduction of a drainage-tube into Douglas' pouch.

Radical Cure of Oblique Inguinal Hernia.—Dr. MacEwen, of Glasgow, contributes an interesting addition to the literature of radical cure of hernia. He holds the view that by the usual methods of radical cure of oblique inguinal hernia, a funnel-shaped puckering of the peritoneum is left with the apex opposite the internal ring. When the liquid movement of the intestine, as it glides over the peritoneum, is thrown into the form of a wave by the sudden impulse of straining or coughing, it is carried into the pouch which guides it into the canal, where it expends its force. It thus acts as a wedge, widening and tending to open up the canal. To obviate these defects, Dr. MacEwen separates the sac carefully, not only from the entire inguinal canal, but

also from the abdominal aspect of the circumference of the internal ring. It is completely reduced from the canal into the abdomen, beyond the internal ring, then thrown into a series of folds, constituting a pad, which is placed on the peritoneal surface opposite the internal ring. It there constitutes a boss or bulwark, with its convexity presenting backwards towards the abdomen, while its base rests on the abdominal walls surrounding the circumference of the internal ring. This not only protects the internal ring, but sheds the intestinal wave backwards away from the opening.

Having secured the peritoneal surface, he considers it advisable to bring the sides of the dilated inguinal canal together. This is best done by drawing the conjoined tendon towards the fixed unyielding ligament of Poupart, and uniting it with the transversalis and internal oblique muscles. Dr. MacEwen has devised a specially curved hernia-needle, with which he carries a thread twice through the conjoined tendon —from without inwards near the lower border, and from within outwards as high as possible on the inner aspects of the canal. Two free ends are thus left with a loop on the abdominal surface. The ends are then carried through Poupart's ligament and the transversalis, internal and external oblique muscles, each end being carried through at the level of its emergence from the conjoined tendon. To complete the suture, the ends are drawn together and tied in a reef knot. The same stitch may be repeated lower down the canal if thought advisable. This operation has been performed thirty-three times for radical cure, and the results have been so satisfactory that one patient only has been found subsequently to wear a pad and bandage. In this instance the patient was so accustomed to his truss, that he felt a want when there was no bandage over the part.—*Annals of Surgery*, August, 1886.

The Antiseptic Treatment of Erysipelas.—Dr. Haberkorn contributes in the *Centralblatt für Chirurgie*, May 8th, 1886, a short but emphatic recommendation of benzoate of soda as an internal remedy for erysipelas. He treated fifty cases with this drug, giving 300 grains daily, and asserts that in nearly every one the temperature fell and the local symptoms improved within about twenty-four hours from the commencement of the treatment. No local measures were employed. The method recommended has certainly advantages, in respect to the patient's comfort, over carbolic acid injections, scarification, &c.—*International Journal of the Medical Sciences*, October, 1886.

Resection of a Cancerous Œsophagus.— Mikulicz (*Prager med. Wochenschrift*, 1886, No. 10) succeeded in resecting the upper end of the œsophagus for carcinoma in a woman aged fifty. After preliminary tracheotomy and the usual incision for œsophagostomy, the lower end of the canal was secured to the skin wound. Four months later, obliteration of the fistula was obtained by a further operation, and it was not until two months more had elapsed that a recurrence of the growth was noticed, and this proved fatal about a year after the first operation.—*International Journal of the Medical Sciences*, October, 1886.

The Local Treatment of Pseudo-membranous Croup, Intubation of the Larynx.— Professor J. Lewis Smith expresses his belief that intubation of the larynx is destined to be employed more generally than tracheotomy in the treatment of croup. In the early stages of the disease he recommends inhalations of trypsin and strong alkaline solutions. If the patient does not benefit by this treatment, he advises intubation. This operation was first practised by Bouchût, of Paris, in 1858; independently by O'Dwyer, of New York, in 1883. Bouchût used a short tube less than an inch in diameter, which resembled a small thimble open at both ends. He closes a paper he wrote on the subject with the following remarks:

(1) The ease with which we can practise tubage of the glottis by means of a canula fastened upon the inferior vocal cords and not hindering the functions of the larynx.

(2) The tolerance of the canula by the larynx.

(3) The possibility of relieving the dyspnœa of croup and of other diseases of the larynx by this means in preference to tracheotomy.

(4) The facility with which large pseudo-membranous concretions formed in the trachea and bronchial tubes are expelled through the intra-glottic tube.

(5) The utility of this new resource (tubage) for physicians who practice in small localities without helpers and far from assistance, since little aid is required in introducing the tube.

O'Dwyer's tubes extend the whole length of the larynx and trachea, to within half an inch of the bifurcation. Professor Smith considers the following facts proved by the statistics of intubation:

(1) The tube can be inserted in less than half a minute. The operation causes no pain; and the only assistant required is a nurse to hold the child and steady its head.

(2) In all cases in which the obstruction is limited to the larynx and trachea, intubation relieves the dyspnœa as quickly, effectually and permanently, as does tracheotomy.

(3) When inhalation and medical treatment fail to relieve croup, and dyspnœa begins, intubation is required. If respiration subsequently become embarrassed, and no benefit occur from cleaning the tube, tracheotomy may be required.

(4) Many parents who object to tracheotomy will allow intubation.

(5) Country practitioners should be provided with the instruments for intubation. This operation may prevent the need of tracheotomy; if not, it presents no hindrance to it, and will probably give the physician time to prepare for the major operation.

O'Dwyer's tube may prove serviceable as a guide in tracheotomy.—*International Journal of the Medical Sciences*, October, 1886.

Dr. F. E. Waxham publishes the results of 83 cases of intubation, with a percentage recovery of 27.7; and compares this with 306 cases of tracheotomy, with a recovery of 18·95 per cent.—*Cincinnati Lancet-Clinic*, July 24th, 1886.

Chancre of the Gum.—Dr. D. L. Kinsman reports this case in the *Cleveland Medical Gazette*. The patient, B., first consulted him on June 24th, for a swelling of the cervical and submaxillary glands of the right side. An ulcer was found surrounding the right middle incisor of the upper jaw. On July 3rd a papular syphilitic eruption appeared on his face, chest, and arms. Under specific treatment he did well. Three years ago B. was treated for syphilis, the diagnosis of which was based on the occurrence of a sore on the penis, and a consecutive suppurating bubo. He had then no secondary symptoms. For some time the origin of the chancre on the gum was a mystery; finally, it was discovered that he had been having sexual relations with a young woman for twelve months. The early part of last May this young woman, who, until then, had been free from all sores, had a fissure on her lip. This was cauterised with a crayon of nitrate of silver. The fissure then took on the appearance of a broad-based sore, and she subsequently had secondary syphilis. B. supposed he had been infected by kissing her while her lip was sore. Dr. Kinsman was led to believe that the girl was contaminated by the crayon of nitrate of silver, which may have been soiled by contact with a chancre on someone else. This case, as well as others, teaches us we cannot be too careful to protect others

from contamination by soiled instruments, which have been used about syphilitics.—*The Medical and Surgical Reporter*, October 9th, 1886.

Gastrotomy for Removal of a Fork from the Stomach.—M. Polaillon presented this case to the Academy of Medicine at Paris. A juggler swallowed a fork by accident on August 5th. Beyond a little spitting of blood, due to excoriation of the pharynx and œsophagus, he suffered no inconvenience, and the next day continued his juggling exercises as if nothing had happened. After a few days he felt some uneasiness in the pit of the stomach, and was admitted into the La Pitié Hôpital on August 14th. Notwithstanding the slender form of the patient, the fork, a tinned one of large size, could not be felt. The patient suffered when his stomach was empty; he was, therefore, obliged to eat frequently to prevent pain. There was no vomiting or spitting of blood. An œsophageal tube charged with a metallic stylet was introduced, but nothing was felt. To clear up the diagnosis, M. Polaillon enlisted the services of M. Trouvé, the well-known electrician, with the following result:

1. A magnetic needle of extreme delicacy turned toward the epigastric region of the patient whenever he approached the needle, and it was interesting to notice that the needle followed the patient's movements.

2. A large electro-magnetic apparatus, placed a few millimetres from the abdominal wall suddenly produced, while the electric current was being passed over, a slight arched elevation of the skin, as if a body intra-abdominal rushed towards the electro-magnetic machine.

The evidence was considered conclusive, and an operation decided on. The stomach was opened about the level of the ninth rib, and an iron fork, 21 centimetres long and weighing 59 grammes, was removed. M. Polaillon, contrary to the usual custom, sutured up the stomach separately and completely, leaving the organ free in the abdominal cavity. Up to Sept. 25th the patient was progressing favourably.—*The Medical Record* (New York), Sept. 25th, 1886.

Passage of Open Penknife along the Intestinal Canal.—The patient, a young man 20 years of age, while fooling with some boys and girls, swallowed an open penknife, handle first. Dr. Hutchings, under whose care he was placed, directed him to eat a hearty meal of mush and buckwheat cakes, and on going to bed instructed him to lie on his right side, to facilitate the passage of the knife into the duodenum. The next day he was directed to lie on the right

side, with his hips elevated, and to eat freely of any food he desired, especially buckwheat cakes. On this day his bowels were moved, and he states that he felt the knife pass through the ileo-cæcal valve. Three days after swallowing the knife, he felt it in the sigmoid flexure, and, later in the same day, pricking at the anus. The next day he passed a very copious motion, which brought away the knife, point first. Dr. Hutchings states, that if there had been diarrhœa, he would have given opiates to check peristalsis. He believes that, in all cases when a sharp-pointed instrument has been swallowed, bulky non-concentrative food should be given, to distend the bowel, and thus prevent the object from catching in any of the folds of the intestine. The knife measured $3\frac{1}{2}$ inches; the point was quite sharp, and the rivets of the handle projected a sixteenth of an inch, owing to the worn condition of the blade.—*Pacific Medical and Surgical Journal*, January, 1886.

Abortive Treatment of Mammary Abscess.—Dr. Llewellyn Eliot, of Washington, having seen the beneficial results of the free application of spirits of turpentine to abscesses and whitlows in their early stages, was induced to try the same treatment in the incipient stage of mammary abscess. He writes: "If, upon the discovery of a drawing pain upon suckling, or a tender hard spot in any part of the gland, the part be bathed with spirits of turpentine, and then covered with a cloth rag or piece of flannel saturated with the same, we may, as a rule, look for the disappearance of the hardness, the tenderness, and all other uneasiness attending this troublesome affection, in the course of two, or at the most three, days. During the course of such a treatment the child may be nursed from the affected breast; but not as frequently as from the healthy one. It is hardly necessary to say that all traces of turpentine should be washed away before such nursing. The amount of milk secreted has never appeared lessened in the cases observed, nor have any of the ill results of the continued use of turpentine followed, either in the mother or in the child." Dr. Eliot does not claim infallibility for his method; but, at the same time, states that his faith now centres round the application of spirits of turpentine as an abortive of mammary abscess. Even if unsuccessful, it will be attended with no bad result.—*The Medical Record* (New York), July 31st, 1886.

Puncture of the Nerve-Sheath in Sciatica.—Sir Joseph Fayrer relates this case: The patient, a middle-aged man, had no history of syphilis, rheumatism, or gout, nor any other satisfactory explanation of the cause of the disease. The

pain was severe, continuous, with paroxysmal exacerbations: all the usual methods of treatment had failed. On careful examination, a fulness and tenderness, with some feeling of fluctuation, was detected along the upper part of the course of the sciatic nerve. Sir Joseph thereupon introduced a long narrow knife into the swelling, until it entered the nerve-sheath, and gave exit to about two drachms of clear serous fluid. This was followed by immediate relief of suffering, and rapidly resulted in complete recovery. Sir Joseph Fayrer refers to the success attending acupuncture with needles in cases of deep-seated pain, and thinks it possible the result may be due to the relief of tension following the evacuation of the fluid which has accumulated as the result of inflammation of the nerve-sheath.—*The Practitioner*, April, 1886.

Grafts of Frogskin.—In spite of an unfavourable experience of skin-grafting in burns, &c., Professor Morales Perez tried, in a case of burn of the hand, the lately recommended plan of engrafting frogskin. Three quadrangular grafts, two centimetres wide by three long, were first applied, medicated wool and iodoform ointment being the dressings used. After five days these grafts were found to have adhered, with the exception of two small bits. Two fresh grafts were applied at other points, and these adhered well. After some days the epidermis and the blackest green pigment of the graft dried up, and was detricted in fine scales, leaving a thin white cicatrix. Finally, a very satisfactory elastic cicatrix was obtained, the line of the grafts being visible.—*London Medical Record*, October 15th, 1886.

Resection of the Lung, and Extirpation of a Kidney.—M. Demons read an interesting note at a recent meeting of the Paris Surgical Society. An adult was stabbed between the ninth and tenth ribs. A portion of the lung tissue protruded, and formed a mass about as large as an apple. The same day the patient passed blood with his urine, indicating a wound of the kidney. M. Demons resected, by means of an écraseur, the hernial portion of lung, and applied the thermo-cautery to the surface. Some days after the operation, there was purulent effusion on the left side of the thorax; chemical analysis of the fluid proved it to be principally urine. It was decided to remove the kidney. Nephrectomy was performed in the lumbar region. The twelfth rib made the operation more difficult; but M. Demons, remembering M. le Dentu's opinion, carefully avoided cutting it. The pedicle of the kidney was divided, and carefully ligated. The wound was sutured with metallic threads: union took place by first

intention; but two months subsequently a mass of cellular tissue sloughed away and opened the cicatrix. It is now six months since the operation was performed, and recovery appears to be perfectly established.—*The Medical Record* (New York), October 2nd, 1886.

ABSTRACTS.

By J. Michell Clarke, M.B. Oxon, Assist. Physician to Bristol General Hospital.

Myxœdema following Extirpation of Thyroid.—M. Reverdin, of Geneva, has lately published a series of cases in which the symptoms of myxœdema followed total extirpation of the thyroid gland. He proposes the name of "operative myxœdema" for the group of symptoms, which are as follows:—After two or three months the subjects of operation complain of fatigue and of clumsiness of the limbs. The face is anæmic; later the face, hands, and extremities swell. The swelling of the features renders them immobile, and gives the patient the appearance of cretinism. Painful sensations are felt in the head, chest, and back, with a general feeling of chilliness. Finally trophic troubles appear, the skin becomes dry and scaly, the hairs break and fall out, and there is slowness of speech with loss of memory. Sometimes a small amount of albumen appears in the urine; the heart and lungs remain healthy.

M. Reverdin cites the experiments of Professor Horsley on monkeys, and points out that the above symptoms do not always follow total extirpation of thyroid. Out of 18 collected cases, operative myxœdema followed in 16; and out of 12 cases operated on by himself, it occurred in five. Of these five, one died of pulmonary phthisis; in one the symptoms of myxœdema have steadily progressed; in another they vary in intensity from time to time; and in two, in which part of the thyroid was accidentally left, are only present in part. In one of the latter it is interesting to note that the portion of the gland left has atrophied.

He draws the following conclusions:

1. The symptoms following extirpation of the thyroid are identical with those of myxœdema.

2. Total extirpation is not invariably followed by myxœdema.

3. "Operative," unlike medical myxœdema, is capable of improvement, perhaps even of cure.

4. In cases where improvement takes place, little nodules sometimes develop a long time after the extirpation of the thyroid, which probably arise from "aberrant" lobules of the gland; but improvement may take place in cases in which these nodules do not appear. — *Gazette des hôpitaux*, October 21st, 1886.

THEORY OF ORIGIN OF TETANUS.—At the Congress of French Surgeons, a discussion on Tetanus took place, during which M. Verneuil, of Paris, said that he considered tetanus to be a specific, infectious disease, that it depends on a special microbe, and that it is communicated to man from horses. To show its endemicity, in one village every operation on a horse is followed by tetanus. To show its contagious properties, in a village in the Ardennes three horses castrated on the same dungheap by one veterinary died of tetanus; ten horses castrated by the same veterinary in neighbouring villages died of tetanus; while another veterinary operating in the same country-side had not a single death, nor any symptom of tetanus, amongst the horses he castrated. Men affected with tetanus, on the other hand, do not give it to horses, just as dogs do not take hydrophobia from rabid men. He concludes that (1) tetanus in man occurs in those who have more or less to do with horses, provided they receive a wound; (2) tetanus in man follows wounds received from horses; (3) tetanus in man occurs in those who have not actually been injured by horses, but who have a wound that has been in contact with ground contaminated by fæcal matter from horses.

M. Larger related the case of a workman who was injured by machinery in 1885, and carried into a room in a neighbouring house and was seized with tetanus. In 1874, in the next room to that in which he lay, and separated from it only by a rough partition of boards, there was also a case of tetanus. He brings this case forward to show the vitality of the tetanus germ.

M. Blanc, of Bombay, in which place tetanus is endemic, stated that it occurred at the seasons in which cholera is most prevalent. It occurs in three forms: An acute, always fatal form, lasting four to five days with high temperature, rising towards the end; a subacute form, duration twelve days, very frequently fatal, death generally occurring on the tenth to twelfth day; a more chronic and milder form, without fever, generally ending in recovery, and lasting 30—60 days. He states that tetanus is also very prevalent amongst horses in Bombay. In a long series of cases he has found

no specific drug, and says that bromide of potassium is contra-indicated, and that no dressings that have any tendency to irritate should be applied to the wounds.—*Gazette des hôpitaux*, October 21st, 1886.

A Case of Pneumotomy (at the Trosseau Hospital, under M. Preugrueber).—The patient was a child of twelve years old. On admission a large cavity was detected in the right side, the expectoration was fœtid and abundant, the gangrenous odour from it being so strong as to penetrate throughout the ward. The diagnosis was made either of a gangrenous cavity following the mortification of a patch of broncho-pneumonia, or of an interlobular empyema opening into a bronchus. There was no tubercular family history, and the tubercle bacillus was not present in the sputum.

Pneumotomy seemed to afford the only chance of recovery to the patient. An U-shaped flap of skin was raised in the antero-lateral region of thorax with a diameter of about 10 cc., the latissimus dorsi divided, and fifth and sixth ribs exposed. A piece of bone 5 cc. in length was resected from each of these ribs. The pleura, firmly adherent, was seen to rise and fall in the wound with the movements of respiration. The thermo-cautery, moderately heated, was then introduced into the lung to a depth of 3 cc. The lung appeared, though tough, fairly healthy, containing no caseous nodules. At this depth of 3 cc. the instrument entered a cavity, from which foul-smelling gases and bronchial secretions escaped. A free incision into the lung of the same length as the opening in the chest wall was then made with the cautery, and a second incision made at right angles to this. The cavity was not washed out, as, in the author's opinion, drops of fluid during washing tend to pass into the lung tissue, and thus provoke violent suffocating cough. No blood was lost during the incisions into the lung. A large drainage tube was introduced, and the wound dressed with iodoform. During the administration of chloroform much difficulty arose from the secretions of the cavity running into and obstructing the bronchi of the healthy lung (the patient lying on the sound side).

Air freely passed through the opening with every movement of respiration, but ceased to do so on the third day. The cavity was then washed out with a 1 % solution of carbolic acid. The wound took a healthy granulating appearance, the purulent discharge and the offensive odour diminished, but very slowly, and three weeks from the operation, when the case was reported, had not disappeared. The

patient rapidly improved in health and strength from the first.—*Gazette des hôpitaux*, November 6th.

HYDROPHOBIA.—*Report by M. Pasteur.*—M. Pasteur stated that he began his work on November 1st, 1885, and that on October 31st, 1886, 2,400 persons had undergone treatment at Paris. The treatment lasted ten days. Each day the patient received an injection of rabbit's spinal cord, beginning with cords of the fourteenth and ending with cords of the fifth day. The treatment was uniform for the large majority of cases, irrespective of age and sex, of the number, situation, and depth of the bites, and of the time elapsed since the patient was bitten.

Of these 2,400 people, 1,700 were from France or Algiers. Of these, 10 died from hydrophobia. Nearly everybody bitten by mad dogs in France during 1885–86 came to M. Pasteur to be treated. Of the very small minority not treated by him, 17 died from hydrophobia. The average number of deaths from hydrophobia in Paris during the last five years is 12 per year. Since November 1st, 1885, three died in Paris. Of these, two were not inoculated, and the third was not treated by the more powerful methods described below.

Seeing that of the 10 fatal cases out of the 1,700 above, five were children and bitten in the face, and that of the 19 Russians bitten by a rabid wolf one died during the course of the treatment detailed above, and two some days after it, M. Pasteur was led to infer that the inoculating material was not virulent enough; he therefore carried the inoculations of the other 16 Russians to strengths of the fourth, third, and second day, with the result that these 16 all recovered. M. Pasteur inferred that in the fatal cases the material injected was not sufficiently active, and therefore adopted a more quickly-acting and energetic mode of treatment for all cases.

In the case of bites on bare surfaces, and where there are many and deep bites, he now injects on the first day of treatment material from spinal cords of the twelfth, tenth, eighth days at 11 a.m., 4 p.m. and 9 p.m.; on the second day of treatment, virus from cords of the sixth, fourth, and second days at the same hours; on the third day, material from spinal cords of the first day. The course of treatment is then undergone again, beginning with more recent material than the first was begun with, and ending on the sixth day, when a third course is begun; so that in ten days the patient has received three series of inoculations, each of the two last with virus of more recent date than the preceding one, and

beginning all three series and ending with the injection of material from cords of the first day.

If the bites have not cicatrised, or a long interval has elapsed between the bite and inoculation, the same course of treatment is repeated.

This more energetic inoculation has been practised for two months; and in proof of its value, M. Pasteur compares the six fatal cases in children mentioned above, who were treated by the milder method, with ten cases of children, also seriously bitten, treated in August on the most recent plan. Hydrophobia comes on in children severely bitten in from 4—6 weeks, and none of these ten show any symptoms of it so far.

Before this more energetic inoculation was determined on, M. Pasteur repeated his experiments on dogs. In all cases intracranial inoculation by trephining was practised with virus obtained from dogs suffering from hydrophobia. He found that success in vaccination of animals, after their inoculation by trephining, depends on the rapidity and intensity of the vaccination, and that the first series of vaccinations should begin on the day following infection and be completed in 48 hours, then to be followed by two more series at short intervals. —*Bulletin d'Acad. de médecine*, November 2nd, 1886.

M. Colin, of Alfort, criticised this report of M. Pasteur's on November 9th. He said that he could not allow that 2,400 people, of whom 1,700 were French, had been bitten by mad dogs. The individual elements of the statistics were often made by persons incompetent to judge whether a dog was rabid; and again, it was often impossible even after an autopsy on a dog to say positively that rabies was present. He brought forward a number of cases in support of this, and therefore held that errors from these sources necessitated a considerable deduction from M. Pasteur's numbers.

Further deductions must be made—first, for discrepancies between the statistics of the administrative department and M. Pasteur's; secondly, in view of the fact already proved, that all men or animals bitten by rabid dogs do not contract rabies; thirdly, for persons bitten, but whose bites have been cauterised.

Deduct the sum of these groups from M. Pasteur's number of people treated, and the remainder will be those to whom inoculation has been beneficial. This number would in other words correspond to the number of people who died of rabies before M. Pasteur's inoculations took place, or about 30 annually; so that, deducting the 10 fatal cases, 18—20 people have been cured by inoculation.

So that the results of M. Pasteur's treatment are not what they appear to be at first sight; if it has been successful in some cases, it has failed in a relatively large number. What led M. Colin to doubt the infallibility of M. Pasteur's method was the known result of preventive inoculations for anthrax. Immunity here is not always acquired, is of limited duration, and the inoculations practised with a view of obtaining this immunity are often dangerous and bring on the disease in a fatal form.

Now, M. Pasteur has declared positively that his inoculations with attenuated virus confer absolute immunity in all cases, without any risk. But facts have shown it to be otherwise. He has been obliged to subject his patients to two or three series of inoculations to obtain an immunity, deceptive in character and of short duration, and a large number of animals have been killed with virus said to be harmless. Relatively to anthrax, inoculations in rabies do not seem to be so dangerous; but it is to be feared that these later vaccinations with virus from rabid cords of the third, second, and first days—if they are indeed very active—will produce rabies, just as vaccination with virus of anthrax produces that disease.

"May we not say, with some truth, that such accidents have already come to the knowledge of the vaccinators themselves and of the public?"

In conclusion, M. Colin wishes Pasteur all success in his efforts in the cause of humanity, but claims at the same time the right of free discussion and criticism of his results.—*Bulletin d'Acad. de médecine*, November 9th.

NOTES ON DISEASES OF THE THROAT.

By Barclay J. Baron, M.B. Edin., Physician in charge of the Throat Department of the Bristol General Hospital.

1. The Treatment of Tubercular Ulceration of the Larynx by Lactic Acid.—*Revue mensuelle de Laryngologie*, July, 1886.—Krause first used lactic acid in this formidable disease, and considers that he has had very good results from it. Jellinek confirms Krause's observations. Hering has carefully studied the matter, and of twenty cases has had—four, complete cure; two, almost complete cure; four, considerable amelioration; six, functional amelioration. The cases in which most good

can be obtained are those in which the ulcers are circumscribed, and are on the vocal cords or epiglottis, the pulmonary affection not being far advanced. On the other hand, crater-like ulcers of the ventricular bands, or of the interarytenoid mucous membrane, usually have to be scraped, deeply incised, or cauterised by chromic acid, before the lactic acid is applied. Hectic fever, emaciation, much dysphagia due to ulceration, and advanced pulmonary affection, are contra-indications to its use.

Method of application: First brush a 10 per cent. solution of cocaine over the affected parts, then swab on with piece of cotton wool a 20 to 30 per cent. solution of lactic acid. After a few days the solution of the latter may be of 80 per cent. strength, or even as concentrated as possible; the cocaine can be dispensed with, as the parts become more tolerant. The operation must be repeated every day until an eschar forms. In addition to this local treatment, attention to the general health is of great importance.

Fraenkel and Schrötter approve of this method of treatment. Schnitzler still believes in iodoform insufflated into the ulcers.

Rosenberg has got good results from a 20 per cent. solution of menthol in olive oil, locally applied.

[I have had good results from repeated and accurate insufflations of pulv. iodoform, which leads to healing of the ulcers and subsidence of fœtor, and, with cocaine to keep down pain, is certainly very valuable.—*Trans.*]

2. The Treatment of Epistaxis.—German Med. Soc., Strasburg, Sept. 9th, 1886.—Kiesselbach agrees with Michel and Voltolini that epistaxis is due, in a great many cases, to dilatation of the capillaries of the mucous membrane of the antero-inferior part of the cartilaginous septum, whereby a cavernous tissue, like that covering the turbinated bones, is produced. Destruction of this membrane prevents further bleeding.

3. Syphiloma of both Vocal Cords.—*Rev. mens. de Laryngologie*, February, 1886.—Eeman publishes this case of a street hawker, aged 55, who had tertiary sub-cutaneous syphilis, and who complained of symptoms of hoarseness *without dyspnœa* for 34 years, and of aphonia, with constantly increasing dyspnœa, anæmia, loss of flesh, and debility, for a few months. Laryngoscopy showed anæmia of the larynx, except the vocal cords, which were reddened, and had swellings on them, so that on attempted phonation, the swollen parts touched each other, and thus prevented audible voice; the orifice of the

glottis also was much lessened in size, and so dyspnœa was produced. The redness of the right cord was not uniform, being most intense nearest the free edge and on its posterior half.

Treatment consisted of inunction of ung. hydrarg.; and internally potass. iodid.

In seven weeks the laryngoscopic appearances were normal, and aphonia and dyspnœa had disappeared. This case is interesting—(1) as bearing out Ziemssen's dictum, that those who use the vocal apparatus very much, and especially in the open air in changeable weather, as this woman did, are more liable to syphilitic affections of the larynx than others, if they are attacked by the syphilitic poison; (2) as a specimen of gumma in the stage of infiltration, which is not often seen; (3) from its having been cured by general treatment alone.

[At the present time I have under my care a woman who has been a street hawker, who has had syphilis, and who for five years has suffered from hoarseness, pain in speaking, and dyspnœa after exertion.

Laryngoscopy showed: both vocal cords much thickened and of dark red colour, above the left cord a fleshy outgrowth, and very great hypertrophy of the interarytenoid mucous membrane, and of the posterior laryngeal wall.

Under antisyphilitic treatment the vocal cords are not so thick nor so red, the outgrowth on left side is not quite so prominent, there is much less pain in speaking, and the patient says that she has not breathed so freely for years.

The outgrowth and hypertrophied mucous membrane will need to be destroyed with chromic acid or some caustic, and then, I believe, the voice will become clearer.—*Trans.*]

4. Erysipelas of the Larynx.—*Rev. mensuelle de Laryngologie*, February, 1886.—Massei has written elaborately on this affection, and sums up thus:—

1. There is such a disease as primary erysipelas of the larynx.

2. This is not very rare, the majority of the cases of so called acute laryngeal œdema being of this nature.

3. Local symptoms may predominate; or on the other hand, those connected with the general condition may be more prominent.

4. Treatment: (*a*) Cold locally, tonics, &c., generally, and purgatives; (*b*) scarification; (*c*) tracheotomy if suffocation threaten.

5. Disagreeable Sensations in the Throat.—*Internat. Centralblatt für Laryngologie*, July, 1886.—Schmiegelow says that when these arise from a pathological condition of the pharynx at the level of the uvula, they are almost always referred by the patient to the thyroid cartilage, or even lower down, to the cricoid. This inability correctly to localise the seat of mischief by sensation, is due to weak localising power of the mucous membrane of the part.

[This is a very important matter, and from personal experience I fully agree with the proposition that patients complain of pain, a feeling of obstruction, &c., in the larynx, when the laryngoscope reveals no laryngeal trouble, but when the uvula and pharynx are congested. The bearing on diagnosis, prognosis, and treatment is obvious.—*Trans.*]

6. Emetics in Croup.—*Internat. Centralblatt für Laryngologie*, August, 1886.—Massei believes that these are too frequently prescribed, since the hindrance to the entry of air into the lungs is due more to a pseudo-anchylosis of the crico-arytenoid joint, produced by swelling, than to false membrane. Deferring tracheotomy until too late to be of value is the danger of using emetics.

7. Improved Nasal Bougies.—*Edinburgh Med. Journal*, August, 1885.—The following is the formula: Gelatin., 30 parts; aq. dest., 45 parts. After soaking for 12 hours, add glycerin., 45 parts, and mix in a water bath. Any drug—as, *e.g.*, belladonna, cocaine, tannin, &c.—can be added.

8. Quinsy as a Rheumatism.—*Chicago Med. Journal and Examiner*, March, 1886.—Knox formulates his opinions thus:

1. Acute tonsillitis is, as a rule, a rheumatic inflammation.
2. Eighty per cent. of such cases are cured by anti-rheumatic drugs.
3. Acute non-rheumatic tonsillitis is not affected by these drugs.

[There is no doubt that rheumatism plays a part in the production of tonsillitis; and when it is associated with pain in the limbs and joints, and especially if there is a history of previous rheumatic tendencies, I am in the habit of prescribing salicylate of soda, and with excellent results, but Knox assesses the number of such cases too high in his article.—*Trans.*]

9. Uniting of the Vocal Cords from Syphilis.—*Internat. Centralblatt für Laryngologie*, August, 1886.—Schnitzler had a syphilitic case in which the patient had suffered from infil-

tration of the apices of the lungs, and ulcers in the vocal cords, on the velum palati, and on the uvula, for three years. During the last year the vocal cords had been united in front by a membrane, gummata, and ulcers being found on their extremities. Inunction, with ung. hydrarg. and cutting through the membrane, did much good.

10. CHOREA LARYNGIS.—*Internat. Centralblatt für Laryngologie*, August, 1886.—Masucci publishes two cases—children, aged respectively 12 and 9 years, in whom the same symptoms were found; viz., attacks of coughing, of a peculiarly rough character, and which ceased during sleep. Laryngoscopy showed slight hyperæmia of the vocal cords. Morphia insufflations, bromide of potash, and the use of faradism were curative. Faradisation alone cured, in one of the cases, in which the cough returned; so that the author considers that the application of electricity is the proper treatment of these cases.

11. DYSPHAGIA OF NERVOUS ORIGIN.—*Norsk Magazin for Lægevidenskaben*, p. 43, 1886.—Leegaard reports the case of a strong man, 72 years old, who had had neither syphilis nor diphtheria. For two years he had experienced difficulty in swallowing—*at first fluids, later solids*—and he had a feeling as if the food stuck in his throat. He was well nourished; could scarcely whistle at all, his tongue showed fibrillary twitching, but no atrophy nor paresis. Velum palati moved slowly, but tolerably well during intonation. Posterior wall of the pharynx did not react to touch. Sensibility in the throat normal. Voice and pronunciation of words normal. No œsophageal stricture.

The condition was regarded as one of glosso-labio-laryngeal paralysis, of very slow development, and with peculiar commencement.

12. LARYNGEAL PARALYSIS OF CENTRAL ORIGIN.—*Rev. mensuelle de Laryngologie*, March, 1886.—Cartoz reports four cases from Charcot's clinique. The first was that of a man, 57 years old, affected with bulbar paralysis, who had a hoarse whispering voice. Laryngoscopy showed incomplete paralysis of the abductors and tensors of the vocal cords.

The second was a man 49 years old, also suffering from bulbar paralysis. Laryngoscopy revealed swelling of the ventricular bands, a small erosion of the right vocal cord, and paresis of the same muscles as in last case.

The third was affected with glosso-laryngeal paralysis, and in him the vocal cords did not meet at their anterior

and posterior extremities during phonation, the left cord was less movable than the right, and the voice deep and broken.

The fourth was a case of lateral amyotrophic sclerosis; the epiglottis was dragged towards the left side, the vocal cords were badly stretched, and, therefore, left an ellipsoidal space between them on phonation.

In these cases we have to do with paresis of the muscles of phonation, but the dyspnœa which usually supervenes later in the course of the central disease is probably due to paralysis of the abductors of the vocal cords.

The author also relates particulars of three cases of hemiplegia of central origin, in which the abductors of the vocal cords on the paralysed side, were also paralysed.

13. Some Rare Cases of Perforation of the Nasal Septum.— *Rev. mensuelle de Laryngologie*, November, 1886.— Schmiegelow relates the particulars of three cases:

1. In a man, aged 64, in whom almost the whole of the cartilaginous part of the nasal septum was absent, and which S. thinks is a congenital deformity for the following reasons:

(*a*) It had been present from infancy.

(*b*) There had never been symptoms of nasal disease.

(*c*) There was no history of tuberculosis or congenital syphilis, nor of injury.

(*d*) The mucous membrane evenly surrounded the hole, with no trace of cicatrices.

2. In a lady, aged 33, who had suffered since infancy from epistaxis, especially from the left nostril, which was often obstructed by crusts. Since puberty the bleeding and other symptoms have lessened, and, she would not have known that there was anything the matter with the nose, had not her brother, who is a doctor, accidentally found that she had a perforation of the cartilaginous portion of the septum. The margins of the hole are in part smooth, but in part also ulcerated.

S. considers this perforation due to traumatic perichondritis, caused by the continual irritation set up by "picking the nose," in order to free it from the crusts that had formed as the result of the epistaxis.

She was cured by the application of chromic acid.

3. In a lady, aged 47. She complained of much purulent discharge from the nostrils, also fœtid crusts.

The right nostril was very large, and the left very small, owing to deviation of the septum, and the latter nostril was

almost filled with thick fœtid purulent discharge and crusts, and on cleansing it the mucous membrane of the osseous septum was seen to be granular and rough, over an area as large as a sixpenny piece. Bare bone could be felt with the probe. Cauterising with chromic acid, insufflations of powdered nitrate of silver, scrupulous cleanliness, and scraping with the sharp spoon once, cured the condition. There was no history of syphilis, and the use of pot. iod. before local measures were adopted, was of no value.

NOTES ON PREPARATIONS FOR THE SICK.

SAVORY AND MOORE'S CONDENSED PEPTONISED MILK.—The use of peptonised milk is now so well appreciated that little need be said in its favour, and this particular form of it has the special advantage that it requires no preparation. Even the simplest chemical process is apt to be mismanaged by those who are not familiar with it, and the peptonising of milk forms no exception to this rule; inasmuch as, even now, we are sometimes told that a patient has had lactopeptine administered to him, where peptonised milk was intended; and it has frequently happened that pepsine has been mixed with the milk in a bottle, from which the patient has found some difficulty in extracting the product. The only drawback to the condensed preparation is its sweetness; but even this may, in some cases, be an advantage, inasmuch as we have found it to be an excellent vehicle for cod liver oil.

Messrs. Savory and Moore have provided for the palates of those who complain of the honey-like sweetness of the simple condensed peptonised milk, by the addition of cocoa, in the form of *Condensed Milk and Cocoa*. This combination we have found to be almost universally appreciated, even by those who complain of the sweetness of the other preparation, and inasmuch as the cocoa serves to disguise the milky nature of the compound, it is readily taken by those patients who do not like milk, and, being peptonised, by those who maintain that they cannot digest milk. Even in cases of typhoid fever, where everything but milk is withheld, this combination forms a highly nutritious and harmless variation in the diet. In all cases where peptonised milk is desirable, this cocoa mixture appears to be admissible, and is acceptable to many a patient who will not take milk in the ordinary or in the simple peptonised form.

SAVORY AND MOORE'S MEAT PEPTONE.—This preparation, which has been well known to the physiologist for many years, and which recently has come into demand for the feeding of bacteria (in the production of pure cultivations in sterilised meat jelly, to which a little peptone is added), is made from prime English ox beef, and contains the whole of the fibrine and albumen of the flesh in a peptonised condition. It is accordingly a highly nutritious substance, and one which ought to be of great utility in cases where the peptonising power of the stomach is deficient, and where more substantial foods cannot be taken. It is readily soluble in water, and the solution gives the usual peptone reactions. It cannot fail to be of use in the sick room, and is obviously superior to the various meat extracts which contain only the extractives and the salts.

English manufacturers have not yet done much by way of providing meat powders, either simple, or in part peptonised, for the sick. The various forms of Poudre-de-viande, such as those of La Viande Favrot, Poudre-de-Bifteck Adrian, Poudre Alimentaire de Catillon, la Peptone Defresne, and Peptone Catillon,—these and others are only represented amongst us by Carnrick's Beef Peptonoids, and Savory and Moore's Beef Peptone. Doubtless the method of super-alimentation has as yet not passed beyond the experimental stage; but facts are steadily accumulating in favour of the practice. The introduction of powders of this kind will be likely to produce a demand for them; but meanwhile the meat peptone and the powdered peptone of Messrs. Savory and Moore are somewhat expensive but efficient substitutes.

SAVORY AND MOORE'S PEPTONISING PELLETS.—It is claimed for these, that they are the most convenient, portable, inexpensive, and efficacious peptonising agent that can be procured.

The great utility of the peptonising process rests on its application to the digestion of milk; and it is more particularly for the peptonising of this fluid that the various substances in the market have been devised. The precipitation of caseine in the stomach, the discomfort which arises from the presence of the coagulated mass, the constant passage of the undissolved caseine through the alimentary canal, its frequent rejection from the stomach by vomiting,—these and many other facts abundantly indicate the need for the artificial digestion of caseine in the treatment of disease. There is, however, less need for the conversion into peptone of soluble albumen, and the demand for peptonised meat

jellies must be correspondingly less urgent. As a peptonising agent for milk, we have found these pellets to be very efficient; and it must be an advantage that there should be a diversity of methods in the preparation of peptonised milk: the product may not differ in its physiological value, but the fact that it is prepared in a different way will enable one to overcome the prejudices of those who take a dislike to that which is first prepared for them. It is commonly said that patients will not take peptonised milk except under compulsion, and certainly most patients do at first make some objection to its taste: this objection, however, soon ceases, and the difficulty is not to induce patients to continue, but to get them to discontinue where there is no longer any need for it.

The medical profession, and their patients, are much indebted to Mr. Benger for his introduction of the Liquor Pancreaticus, and it seemed to be a little ungrateful that the introduction of the convenient and efficient tubes by Fairchild should necessitate a desertion of the former in favour of the latter. Now that the powders introduced by Benger have enabled us to return to our former allegiance, it would again be ungrateful that any other method should be adopted which does not present a distinct improvement or advantage of some kind. There are, however, several advantages which the proprietors of the pellets may claim: one of these is the not unimportant one, that patients like and take the product better, and there is less waste in consequence of thickening or deterioration. Further, also on the ground of economy, there appears to be a distinct gain in the use of the pellets, inasmuch as each package is adapted for the peptonisation of twice the quantity of milk, whereas the price of the packets is the same. Another advantage is, that the elimination of the process of boiling simplifies the mode of preparation. Each pellet weighs only five grains, and will sufficiently peptonise for ordinary use one pint of milk in a quarter of an hour. We do not see how it can be possible for the process to be any further simplified, and can only congratulate Messrs. Savory and Moore on the production of so convenient, portable, inexpensive, and efficient a peptonising agent, which we have found to be all that is claimed for it.

Messrs. Oppenheimer Brothers and Co. have forwarded the following preparations:—

Liq. Euonymin et Pepsin Co.
Liq. Euonymin et Bismuthi Co.
Liq. Euonymin et Cascaræ Sagradæ Co.
Fluid Pepsine, acidulated.

These fluids form a well devised and useful series of drugs for the treatment of various classes of dyspepsia. They are elegant, palatable, and efficient. When an acid fluid is contra-indicated, the bismuth mixture will be likely to agree; in other cases the euonymin and pepsine fluid will be a considerable aid to an atonic stomach. We have found that the fluid pepsine has a high digestive power on egg albumen; but its acidity is considerable, and would not be tolerated in cases of gastric catarrh.

Averse as we are to the rapid increase of special preparations of particular manufacturers, we cannot but think there is a field for the above mixtures, which appear to be all the proprietor claims for them, and which we have found to be efficient in many cases where they have been tested.

Mr. James I. Fellows has forwarded us a specimen of his Syrup of the Hypophosphites.

This well-known syrup has attained so great a popularity, not only within the profession but with the public, that it needs no commendation: its success, in the many cases to which we constantly administer it, is shown by its popularity with the patient. Its complex composition, whilst it gives a somewhat unscientific aspect to its use in the scientific treatment of disease, and at the same time protects in some degree against spurious imitations, has this further advantage—that it contains nutriment for the use of *all the higher tissues*, and has accordingly a wide range of utility in all conditions of debility, ranging from the marasmus of the half-starved infant to the failing powers of senility. We have found it to be one of the most valuable tonics in the treatment of the defective nutrition of phthisis.

Messrs. Robbins and Co., of Oxford Street, London, have sent us a few of their special preparations.

Two preparations of Hydrogen Peroxide (H_2O_2)—the one a solution in water; the other in ether, known as ozonic ether.

This latter fluid derives its principal utility as a test for blood, the hydroxyl giving off oxygen to guaiacum resin, and causing the well-known blue colour. It may also be used to purify the air of the sick room; and, internally, has been found useful in the treatment of diabetes.

The solution in water is strongly recommended as one of the most efficient agents for the local treatment of cutaneous irritation, and as a local antiseptic.

Charcoal Capsules—These capsules are filled (and hermetically sealed) with vegetable charcoal fresh from the

crucible. The evidence in favour of the utility of charcoal in relieving flatulent distension is considerable; and if it relieves flatulence by absorbing the gases in the stomach and intestines, the capsule form is the only one in which the drug is likely to be efficient.

ETHYLATE OF SODIUM, the latest of the numerous contributions of Dr. B. W. Richardson to practical therapeutics, is certainly not the least valuable. For the destruction of small vascular growths, where purely surgical measures are either inadvisable or objected to, there is probably no chemical application so valuable as sodium ethylate.

MYTHYLENE, as an anæsthetic, holds a peculiar position. Favoured specially by the surgeons at the Samaritan Hospital, and by many of the pupils trained there, it has still failed to find favour among surgeons generally. It is just possible that some of this disfavour may be accounted for by the impurity of the drug. As the original manufacturers, and as holding the confidence of those who use the anæsthetic, Messrs. Robbins may be relied on to supply the pure drug.

STYPTIC COLLOID is an agreeable and satisfactory substitute for collodion, with disinfectant powers superadded.

ANHYDROUS ETHER, for producing general anæsthesia by inhaling, and COMPOUND ANÆSTHETIC ETHER, for producing local anæsthesia, are preparations for which Messrs. Robbins have justly earned an honourable reputation.

MAX GREGER, LIMITED, have favoured us with specimens of their CARLOWITZ wines. That a generous, wholesome, pure wine is, in many instances, a valuable adjuvant in the treatment of disease, and especially in promoting convalescence, we have no doubt whatever. We have little belief in the special efficacy of special ingredients. Physiological chemistry has not yet fully explained the special advantages of the proximate principles found in beverages; but the spontaneous feeling of all men in all times speaks in favour of the effect of good wine on the vital organs. We have tried Carlowitz on ourselves, and just a little on our patients, and we have found it good. The red wine we consider the best.

Reviews and Notices of Books.

Lectures on Medical Pathology. By H. GAWEN SUTTON, F.R.C.P. Pp. 215. London: BALLIÈRE & Co. 1886.

These lectures were, we are told in the Preface, delivered spontaneously; and they are published from shorthand notes taken during their delivery.

The lectures have all the freedom, crispness and vigour of such spontaneous effusions. They are exceedingly readable, full of suggestive thoughts, utterly devoid of system, and, in expression as well as in matter, very original. They stimulate thought, rather than exhaust knowledge.

One delightful element in these lectures is their brevity. As they are shorthand reproductions, they are no doubt full, and one envies the student who has to listen to a lecture which occupies only three small pages of print. But some of them occupy from ten to nineteen pages; fortunately these are few.

Another pleasing feature is the rhetorical display occasionally indulged in by the author. Scarcely a figure of speech is unrepresented, and not a few poets are quoted. Some of his sentences are efforts of genius. "Health, then, is going 'easy' in everything," he tells us. No healthy man will worry over bills and taxes and patients, we conclude.

Some of the descriptions are graphic. Thus: "It is a terrible thing for a poor patient to be coughing up blood. One of the bravest men I knew, a captain in the army, had profuse hæmoptysis, and I had to quiet his fears. I was anxious to get him home alive. I did that, and helped him by saying, 'Cough it up, captain!' Fear tends to paralyse breathing, and paralyse the right side of the heart:—what chance has a poor fellow if he is coughing up blood and is taken with fear?" What indeed! Not many people cough up blood with perfect *sang froid;* and when they do not, it is

well to know what words to use by way of encouragement, as well as what drugs to prescribe.

Pathological processes are represented in dashing little miniatures, which remind one forcibly of the works produced by a certain class of artists, known as "Impressionists." The representation is broad, suggestive, and facile; full of life, and dealing with only such details as are essential to the conception. There is no elaboration; only clear, broad, distinct touches. In this view we commend the work to our readers' notice.

Memorials of the Craft of Surgery. By JOHN FLINT SOUTH. Edited by D'ARCY POWER, M.A., F.R.C.S. Pp. 412. London: CASSELL & Co. 1886.

This interesting work is the outcome of ten years' laborious investigations by John Flint South. His abundant notes from and copies of ancient manuscripts have been carefully and skilfully edited by Mr. D'Arcy Power, and his work is now before the public in this octavo volume. As Sir James Paget puts it in the Introduction, these Memorials "are not full records of the progress of Surgery in the present usual meaning of the words. They do not tell much of its progress as either a science or an art. . . . They are, properly, as the title says, 'Memorials of the *Craft* of Surgery'—that is, of its business and of the corporate life and government of those who, in successive centuries, practised it." In other words, the work might not inaptly be named "Memorials of the *Craftiness* of Surgeons." The diplomacy and finesse with which surgeons, originally disjointed free lances, gathered themselves into a compact phalanx, excluding obnoxious or unskilled rivals, securing charters, reproving misdemeanants, and upholding their own respectability, may be spoken of as craftiness just as aptly as craft. For instance, more than two centuries ago the Company of Barber-Surgeons showed the world how to escape the disagreeable necessity of paying their debts by becoming bankrupt. And many other curious facts go to create an impression, that in the erection of the magnificent fabric of the Royal College of Surgeons, crafty manœuvres were more potent than surgical craft. Human nature has changed but little since those days; much of it may even now be found among the chiefs of this great College.

Sir James Paget, in the Introduction, protests just a little against the vulgar error of supposing that English surgeons

are, in any fair sense, the descendants of barbers. Of the ills that flesh is heir to, the small ones are by far the most grievous. The clumsiness and the deftness of good and of bad barbers have probably given as much pain and certainly more pleasure than surgery under similar circumstances has given. There is a science in hair, as there is in teeth. We have surgeon-dentists, with diplomas of the College of Surgeons; why should not that august body return to its old allegiance, resuscitate barber-surgeons, and enrich its coffers with their diploma fees? And the chiropodists too—they might claim admission, though we fear their friends the orthopædists might object. A man will be none the worse a surgeon for being able deftly to shave a chin, or extract a tooth, or pare a corn; and there can be no doubt that barbers, dentists, and chiropodists would be all the better artists for the possession of the diploma of the College of Surgeons. Ambrose Paré himself was a barber-surgeon: we need not be ashamed of our descent.

On Cancer of the Mouth, Tongue, and Alimentary Tract. By F. B. JESSETT, F.R.C.S. Pp. 309. London: J. & A. CHURCHILL.

This is a plain, simple, unpretending work of average merit and evident good purpose. The author has had considerable opportunities of studying the diseases of which he writes, and with most of them he possesses a fair work-a-day experience. But Mr. Jessett's experience has evidently been more that of the passive recipient than of the active penetrating explorer. He has treated the diseases which came in his way up to his light and ability; but he has introduced no new thing, and he has not fully shown that he has made himself familiar with the original or even second-hand work of others. He is a safe guide for the general surgeon; he is in no sense a pioneer.

As a result of evident want of extensive reading, if not of want of discrimination, it would be easy to point to many examples of inaccurate balance in estimating the values both of theories and of practices. As examples of the latter, we may make selections from the admirable chapter on Cancer of the Intestinal Canal. On page 233 he says: "Mr. Treves and Mr. Bishop, of Manchester, have devised a form of clamp, which, while differing somewhat in make and shape, *are* [Italic ours] designated for the same purpose of clamping

the gut above and below the part to be excised" . . . (in enterectomy). (By the way, Mr. Jessett's English is not that of Addison or Macaulay.) Now, we are far from saying that the clamps of Bishop and of Treves are not the best in existence; but while he is speaking in this general way of intestinal clamps, we think the name of Rydygier deserved mention for his instrument; and those of Makins (best of all, in our opinion) and Abbe were worthy of a passing notice.

On the next page (234) he says: "Two forms of sutures have been proposed and practised for uniting the divided ends of the intestines in these operations—the one by Czerny and Lembert, the other by Gussenbauer." . . . Two forms! one writer describes and depicts thirty-six! The Czerny-Lembert suture is undoubtedly a good one; but of the thirty-five other known sutures, Gussenbauer's is certainly not second best.

The otherwise admirable chapter on Cancer of the Tongue is somewhat marred by a want of precision in advice as to the selection of an operation, as well as of the mode of performing it. After reading his failure in an attempt to remove a tongue by Whitehead's method, we are left in doubt as to whether he has got the manual dexterity of a Whitehead; but we do not reject Whitehead's operation because it failed in Mr. Jessett's hands. "He would strongly recommend in all such cases as these that the lingual artery should be tied first." So would the reviewer, if the operator was not very skilful with his fingers; but this would not be Whitehead's method, and it would introduce an unnecessary element of danger in the double ligature of considerable vessels.

It would be possible to quote many examples of the faults we have found with the book. Its merits will be found on perusal. We believe that it is an honest record of such experience as the writer, with his lights and opportunities, has been able to gather; and that it gives a fair estimate of the value of so much of the work of others as he has been able to study. Not so much can be said for many medical works.

On Cancerous Affections of the Skin. By GEORGE THIN, M.D. Pp. 87. London: J. & A. CHURCHILL. 1886.

Dr. Thin's original researches in the histology of cancerous affections of the skin are so valuable and so generally known, that this monograph, embodying much of his original

work, and bringing the whole subject under review in limited compass, will be gladly welcomed.

The original histological part of the work is, of course, the most valuable. But the sections devoted to description, diagnosis, and treatment, are clear, sensible, sufficiently full, and quite up to date. The book will well repay perusal, and is worthy of a permanent place on the bookshelves.

Diseases of the Prostate. By Sir HENRY THOMPSON. Pp. 237. Sixth Edition. London: J. & A. CHURCHILL.

A notice of a sixth edition of this work is almost superfluous. Since it was awarded the prize as Jacksonian Essay in 1860, it has remained the English classic on the subject which it deals with. In this edition some modifications and additions have been made in theory and in practice, while a novel classification of prostatic deposits has been proposed.

We confess that we should have liked to have seen more notice taken of the work of certain provincial surgeons who have made reputations for themselves in the treatment of prostatic diseases. It is just possible that, in the light of Sir Henry Thompson's extensive experience, the work of these men is considered valueless; but many men of repute do not think so, and it would have at least given a thoroughness and finish to the work which it does not possess had their labours been referred to. On the other hand, we cannot help noting a tendency to play the foster-father to the offspring of other brains; it is satisfactory that the depth of his affection for such offspring seems to be in direct ratio with the amount of neglect which the real parent has exhibited.

Litholapaxy. By P. J. FREYER, M.A., M.D., M.Ch., Bengal Med. Service. Pp. 115. London: J. & A. CHURCHILL.

We lay down this work fully believing that the author will realise his hope "that the record of a large number of cases of this operation, from the practice of a single operator, may prove interesting to the profession at large, and that the results obtained may have some effect in bringing into more general practice . . . an operation . . . which has a brilliant future before it." Dr. Freyer lost only five out of 128 cases—and one of these was from bronchitis

and exposure. If anything more than this brilliant result could popularise an operation, the clear, simple, practical narrative before us would.

We cannot refrain from expressing our sympathy with Dr. Freyer in his criticism of Sir Henry Thompson's behaviour and language with regard to this operation. With dignity and equability of temper, the author condemns Sir H. Thompson out of his own mouth. We agree with Dr. Freyer, that Bigelow's operation was entirely original, that it was a grand revolution in surgical proceeding, and that, even in the uncouth name Litholapaxy, Bigelow was more than justified in the independent position which he took up. We would further express our agreement by saying that Sir Henry Thompson undoubtedly did condemn Bigelow's operation at the outset; that he subsequently sought to prove that he had been leading up to it, even doing it, for years; that he introduced a modification of Bigelow's instruments (after condemning one or two of them); and that now he writes of it with an implied sense of proprietorship, not as Bigelow's operation, or as litholapaxy, but as "lithotrity at one sitting." Probably it is no use protesting that the lithotrity is not the only or even the major part of the operation; still, we are pleased to observe that Sir Henry's fathering of the proceeding has not done away with Bigelow's name. And we are pleased to find that our practical and experienced *confrère* in India has dared to speak out what we know to have been in the minds of many English surgeons as to this attempt by our leading authority on calculus to minimise the reputation of an American brother.

A Code of Rules for the Prevention of Infectious and Contagious Diseases in Schools. Pp. 31. London: J. & A. CHURCHILL.

This very practical and useful Code has been issued by the Medical Officers of Schools' Association.

In a place like Clifton, where there are so many educational establishments, it seems desirable that there should be some agreement or consensus of opinion among medical men respecting those questions which are constantly cropping up, and upon which we are called upon to advise our patients. Such questions are, When is it safe for a boy or girl to return to school, after having had an attack of infectious disease? or, What period of quarantine is necessary after exposure to contagious fevers? and so on.

This Code of Rules furnishes information on these points of a clear and distinctive kind; and as the Code has been prepared after much care and deliberation, and after obtaining answers to an elaborate series of questions sent to every school of importance in the kingdom, it seems to be an authoritative if not a final statement of the whole question.

Possibly in some matters of detail as to the periods of incubation and quarantine there may be some difference of opinion; but at all events, if there be any error in the Code on these points, it seems to be on the right and safe side.

The Code, which is in the form of a small pamphlet, contains five sections:

1. On the General Hygiene of Schools.
2. The School Infirmary: its construction, arrangement, &c.
3. The Medical Examination of Scholars on admission.
4. General Precautions on admission.
5. Measures to be adopted when an Infectious Disease appears in a School.

These are all discussed briefly and concisely; but the points which are especially worthy of the attention of practitioners are:

First. The periods of quarantine necessary after exposure to infection. They are as follows:

Diphtheria	12 days'	quarantine.
Scarlet Fever	14 "	"
Measles	16 "	"
German Measles (Rötheln or Epidemic Roseola) ...	16 "	"
Chicken Pox	18 "	"
Small Pox	18 "	"
Mumps	24 "	"
Whooping Cough	21 "	"

Secondly. With regard to that important question, When may a pupil who has had an infectious disease go home or rejoin the school? the Code gives the following directions:

"A pupil may go home after scarlet fever in not less than six weeks from the date of the rash *if* desquamation has completely ceased, and there be no appearance of sore throat.

"After measles, in not less than three weeks from the date of the rash *if* all desquamation and cough have ceased.

"After German measles (rötheln or epidemic roseola), in two or three weeks.

"After small pox and chicken pox, when every scab has fallen off.

"After mumps, in four weeks from the commencement *if* all swelling has subsided.

"Whooping Cough.—After six weeks from the outset of the whoop, or earlier if all cough has ceased.

"Diphtheria.—In not less than three weeks when convalescence is completed, there being no sore throat or albuminuria.

"Ringworm.—When the *whole* scalp having been examined, no broken-off stumpy hairs are to be detected."

It will be observed that the Code deals with the ordinary exanthemata mainly, and that nothing is said with regard to enteric or typhus fevers.

The book, however, will be found very useful to parents and school authorities, to medical officers of schools, and to practitioners, as an authoritative guide in questions which are often difficult to decide, and about the details of which there is some divergence of opinion among medical men.

The Parasites of Man. By RUDOLF LEUCKART. Translated by W. E. HOYLE, M.A., M.R.C.S. Pp. 771. Edinburgh: YOUNG J. PENTLAND. 1886.

We are equally indebted to translator and to publisher for placing this splendid, almost monumental work in the hands of English readers. The English literature of human parasites is represented almost entirely by the translation of Küchenmeister's work, now almost obsolete, and by the various treatises of Cobbold, which are by no means exhaustive. The work before us not only fills a gap in our literature, but gives us an opportunity of exhausting available knowledge, and of studying the original work of a master.

For thirty years the author has laboured at his subject. Many hundreds of animals have been used for his helminthological experiments, and the number of parasites investigated was much greater. The work everywhere bears the impress of laborious, original, and accurate observation, with the natural concomitants of clear language, vigorous description, and scientific classification.

The book, though devoted mainly to the entozoa infesting man, offers also an almost complete survey over the present state of the zoology of parasites. The first part of the work gives a general account of the natural history of parasitic life; then follows a systematic account of the parasites infesting man, prefixed in each case by a general sketch of the structure and life history of the groups to which they belong. This volume deals with protozoa and cestoda; a second

volume, now being revised by the author for a second German edition, will be translated from proof-sheets by Mr. Hoyle, and published simultaneously in England and in Germany.

No student of helminthology can afford to be without Leuckart's work.

The Private Treatment of the Insane as Single Patients. By EDWARD EAST, M.R.C S., L.S.A., Member of the Medico-Psychological Association. London: J. & A. CHURCHILL. 1886.

The tide of public opinion having just now set in a direction opposed to public lunatic asylums, more attention will be devoted to the treatment of the insane in private houses. There can be no doubt that, for those cases of insanity in which there is a prospect of ultimate recovery, there are many reasons, both extrinsic and intrinsic to the patients themselves, why complete cure should be more probable and the subsequent contentment of the patients more certain if the treatment has been conducted throughout apart from a licensed institution; it being taken for granted that private asylums are, as for the most part they are indeed, models of perfection in management. For cases of incurable mental derangement, asylum treatment is no doubt in most instances the most convenient plan. Mr. East has published a book of plain and simple directions and suggestions for the treatment of the insane in private houses; he does not claim to have supplied a complete text-book; but the work is full of valuable practical information. To any practitioner who is acting or intends to act as medical attendant to a person of unsound mind, who is not under treatment in an asylum, we can most cordially commend the book.

List of Unregistered Medical Practitioners in Australia and New Zealand. Sydney: L. BRUCK. 1886.

Irregular practice seems to thrive more luxuriantly in new countries than with us. We have not now to do with the causes of this, but merely with the facts as brought before us in this small publication. Many in the list profess to be qualified, and allege certain degrees and diplomas; although it is probable that, if investigated, most of these would be found to have no more value than that of the enterprising herbalist, who when asked to explain the right by which he added M.B. after his name, said the letters only stood for

Medical Botanist. A Sydney practitioner advertises that at his lectures "during the evening the Dr. will sing his local song on the Chinese question, and give an unfailing recipe for the growth of the hair. Ladies and gentlemen matrimonially mated on the stage, and other evidences given of the wonderful science of phrenology." Another of Sydney styling himself "Doctor" sells "The Amora Strengthening Wash and Regenerator," which "strengthens the relaxed condition of the generative organs, and will be a source of relief to married men unequal to the duties imposed upon them; in his own case the result exceeded his most sanguine expectations." A "Specialist" in Auckland advertises: "My first advice to all is—that the very instant you notice anything wrong fly to me, for delay is ruin." A travelling "eminent Oculist, Aurist, etc." in Queensland announces that "he carries with him 2 cwt. of the purest unadulterated vegetable medicines." A "Professor" in Melbourne advertises that "his treatment differs entirely from every other in existence, being quite new and original. Diagnosis intuitive and instantaneous."

Although here we are a long way off this—at all events, amongst qualified practitioners—yet it is well to always remember that no man is a great sinner all at once, and that *facilis descensus Averno*. We should be keenly critical of all deviations from professional rectitude, and should sternly check all attempts made to attract public attention. We are sorely in need of a code of minor morals which, if universally recognised, would raise our profession in public estimation. Such a code would forbid obtrusive and multiplied name-plates; conspicuous carriages and trappings; gratuitous advice, a system much abused and quite uncalled for in places which abound in charities, and often adopted merely with a view to impress those who can pay well; the keeping of open surgeries where professional advice is combined with the sale of tooth-brushes; the hire of a couple of rooms, which are dignified by the title of a dispensary, and free attendance given in some particular branch in which the practitioner hopes thereby to be looked upon as a special authority; the degradation of the profession by the provision of advice and medicine for a sum not much more than sufficient to cover the cost of the latter, if properly prescribed, which would then enable us, by a simple exercise in subtraction, to appraise the former at probably its right value.

These are some of the devices by which the ingenuity of man has brought discredit on a profession that should be noble in its simplicity. In the interests of our common brotherhood, we should discourage them to the utmost of our power.

Spasm in Chronic Nerve Disease: being the Gulstonian Lectuers for 1886. By SEYMOUR J. SHARKEY, M.A., M.B. Oxon., F.R.C.P. London: J. & A. CHURCHILL. 1886.

Dr. Sharkey has been well advised in reprinting in book-form his Gulstonian lectures for the present year, for they are too valuable to be allowed to be nothing more than a mere ingredient in the *olla podrida* which forms the contents of our weekly journals. In treating of spasm in chronic nerve disease, Dr. Sharkey divides the subject into these divisions, viz:—(1) spasm in connection with cerebral motor mechanism; (2) in connection with spinal mechanism; (3) functional spasm. Considering that our present knowledge of anatomy, physiology, and pathology, does not justify us in concluding that there is any efferent motor connection between the brain and the spinal cord except the pyramidal tract, direct and crossed, Dr. Sharkey adduces evidence and arguments to show that it is disease of the pyramidal tract *alone* which gives rise to chronic muscular spasm: this is the more interesting, for, although everyone is agreed that the pyramidal tracts are the most frequent agents in producing spasm, Hughlings Jackson and many other neurologists believe in the existence of "cerebellar rigidity," due to unantagonised cerebral influx. Dr. Sharkey, however, maintains that the cerebellum *per se* has no part in the production of spasm; and that a tumour of the cerebellum does not produce contractures, unless it be in such a position and of such size and substance as to produce pressure on the pons varolii or medulla oblongata, and so press upon some portion of the pyramidal tracts which lie therein. Cases are also quoted to prove that destruction of the corpora striata and optic thalami does not give rise to spasm, so long as the internal capsule remains intact.

In speaking of spasm in connection with spinal mechanisms, Dr. Sharkey concludes that muscular spasm is rarely caused directly by chronic disease of peripheral motor nerves, the distortions often seen in such cases being brought about by the unopposed action of the unaffected muscles. Spasm produced in a reflex manner by disease of afferent nerves can hardly be considered apart from spasm produced by disease of ganglionic cells; for it is doubtful whether stimuli applied to afferent nerves would produce muscular spasm if the centres were healthy. There does not seem to be any evidence that gross disease of ganglionic cells produces spasm; though

impalpable disorders do, such as those resulting from their separation from their cerebral centres.

Upon that subject of confessed ignorance, functional spasm, Dr. Sharkey's remarks are philosophical, interesting, and instructive. He points out that functional disorders of the cerebral motor mechanism produce spasmodic conditions resembling those from gross disease. As in cases of congenital absence of portions of the motor centres of the cortex with correlated non-development of the corresponding portion of the pyramidal tract there are found spastic conditions like those occurring in hemiplegia, it is evident that the mere absence of voluntary motor impulse is enough to give rise to the phenomena in question; and it is legitimate, therefore, to conclude that suppression of the functions of this tract is the cause of functional hemi-spasm. We cannot give space to notice the suggestions which Dr. Sharkey has to make upon other classes of functional spasmodic affections, such as writers' cramp and other "professional hyperkineses," "latent contracture," and so on; but can only conclude by heartily recommending the work as well worthy of being carefully studied, and as reflecting the highest credit upon its author.

Handbook of Diseases of the Ear, for the use of Students and Practitioners. By URBAN PRITCHARD, M.D. (Edin.), F.R.C.S. (Eng.) London: H. K. LEWIS.

In this excellent little work the author has "endeavoured to present a practical manual which shall help the reader to recognise the various pathological lesions of the ear, and to discriminate in the matters of treatment and prognosis;" and the result of his endeavour well fulfils the object desired. It may perhaps be doubted whether another work of this kind was required by students or practitioners; but if this be granted, then the work before us must be looked upon as eminently satisfactory. It is thoroughly practical, and is evidently the work of one who has well worked out the methods of examination described; while the treatment is simple and rational, and such as would be approved by all modern surgeons. There is an appendix of formulæ which will be very useful to the busy practitioner, and the general arrangement of the book is simple and easily understood, which cannot be said of all similar works. We can recommend the book as one of the best small works on Ear Diseases.

The Surgery of the Kidney. By W. BRUCE CLARKE, M.A., F.R.C.S. pp. 176. London: H. K. LEWIS.

This work, coming after Mr. Morris's admirable monograph, does not appear at the most favourable time. It is the Jacksonian Prize Essay of 1886, and was written before Mr. Morris's work appeared. What the Jacksonian Prize is, and how, why, and wherefore it is awarded, we have not the remotest idea. But if, in 1886, it was intended to be given to the author of the best work on renal surgery, then, without a doubt, Henry Morris ought to have received it.

Compared with Morris's work, this one is sketchy and superficial. But it is readable and trustworthy. In these bustling times, when the greatest amount of practical show is sought from the least possible effort of the mind, a work like that of Mr. Bruce Clarke is sure to be appreciated. About details we need not be hypercritical. If we hurriedly reach down our English Dictionary when we meet such a word as "mortary," and wonder whether an Oxford graduate *can* make up his mind as to the spelling of nephroraphy, or nephrorhaphy, or nephrorraphy, or nephrorrhaphy (he wisely gives a choice), we cannot fail to be struck with the easy, almost precocious, definiteness with which the author handles theories and lays down laws of practice. As compared with the elaborate caution in Mr. Morris's monograph, the unhesitating confidence in this one of Mr. Bruce Clarke's is refreshing and even stimulating. Saying the best of both works, Morris's book might be spoken of as able and profound, while Clarke's is clever and taking. Saying the worst, it would be scarcely wrong to speak of the former as heavy, of the latter as flighty.

We have no space for examples; but we would call attention to the last chapter, on "Methods by which one ureter can be temporarily occluded," as being a fair specimen of the whole work. It is clear the author has no experience of what he writes about; indeed, he makes pretensions to none. Yet he is able to write a clear, facile, and generally condemnatory critique of the work of every one else. "Catheterism of the ureters" (he says in the concluding paragraph) "is destined possibly to aid in the diagnosis of a stone in the ureter or in the pelvis of the kidney; but it is difficult to see how it could give any clear evidence of the secreting power of a kidney unless the catheter could be securely fixed in the ureter for some hours at the very least." Now, if catheterism of the ureter was intended only to give evidence on the "secreting

power" of a kidney, and if the catheter were once passed, surely there could be no difficulty in leaving it in for a few hours. He does not tell us that secreting power can be deduced from other observations, and that the characters of the urine can be detected from a drachm as easily as from a pint. Again: the casual manner in which he speaks of sounding a stone in the pelvis of the kidney through the ureter is to a practical mind somewhat irritating. It savours of the free and easy treatment which precocious children give to sacred and profound subjects. The original and enthusiastic surgeon may see and feel with the author; the plodding seeker after information will be left bewildered and amazed.

There is a long bibliography, which is in general harmony with the character of the book. It is neither complete nor representative. Take "movable kidney," for instance. We might pardon the omission of such names as those of Martineau, Rigal, Callais, Buret, or Newman; but no excuse whatever can be made for the neglect of Landau. The same criticism might be applied to every other subject. In almost every instance the author seems to have failed to note the best work of the ablest men. He has picked up and digested such crumbs as fell in his way; he has not groped about for the strongest pabulum. We heartily admit that the affectation of bibliographical knowledge is generally a nuisance; but when, in the preface, our author apologises for an abundance of references which is a poverty, and a completeness of bibliography which he hopes may "lessen the labours of those who are pursuing a similar line of inquiry," we deem it necessary to speak out our candid opinion. And not only are the abundances not complete nor representative; they are sometimes not even correct in quotation of statement.

We have said that the work is pleasant, readable, clever, and mostly trustworthy. The ignorant and honest surgeon will get little guiding information; the critical and informed man will find much to please and interest him. But renal surgery will not be advanced by the book. It is an abbreviated epitome of opinions such as the writer has come across; it is by no means a full or authoritative exposition of knowledge. If it is the Jacksonian Prize Essay, we hope it is far below the standard generally attained by that production.

SCRAPS

PICKED UP BY THE ASSISTANT-EDITOR.

Cooling Medicine.—In the diary of a young lady crossing the ocean the following was found: "At eight o'clock in the evening took a pill. At six in the morning passed an iceberg."—*Birmingham Medical Review.*

Not a Specialist.—At a public dinner in a rising town a local magnate sitting near the chairman was asked what he thought of a certain sherry. He replied: "I dare say it 's very good; but I 'm not an *accoucheur.*"

Too Hasty.—A New York physician boasted at dinner that he had no fear of trichinæ, because he cured his own hams. "Well," said a lady guest to him, "I think it would be preferable to be your ham than your patient." The doctor fled to Germany.

Poor Babies.—An advertisement extolling the virtues of a new make of infants' feeding-bottle winds up as follows: "When the baby has done drinking, it must be unscrewed and laid in a cool place, say under a tap."

A writer advises that, "if the baby does not thrive on fresh milk, it should be boiled."

A Big Fee.—During the cholera epidemic in Nashville, Tenn., the late Dr. Bowling attended an old blind negro, who eked out an existence by playing the flute at the street corners. He recovered, and, with a heart overflowing with gratitude, he took his flute and sat under the doctor's bedroom window, and played it the whole night long. Of all the large fees he ever received, the doctor said this was the largest.—*American Lancet.*

Jenner.—T. C. M., in the *Cincinnatti Lancet-Clinic*, says; "Jenner was much given to versification. On one occasion he sent a brace of ducks with the following lines to one of his patients:

> "'I've despatched, my dear madam, this scrap of a letter,
> To say that Miss Dogby is very much better.
> A regular doctor no longer she lacks,
> And therefore I've sent her a couple of quacks!'"

Tact.—Sir Richard Jebb was once paid three guineas by a nobleman, from whom he had a right to expect five. Sir Richard dropped the coins on the carpet, when a servant picked them up and restored them; three, and only three. Instead of walking off, Sir Richard continued his search on the carpet. "Are all the guineas found?" asked his lordship, looking round. "There must be two still on the floor," was the answer, "for I have only three." The hint, of course, was taken, and the right sum put down.—*Technics.*

An Argument for Teetotalism.—As an instance of "the kind of stuff that takes the rustic by storm," the Rev. Dr. Jessopp, in an article in *The Nineteenth Century*, gives this: 'Ah! you shud ha' heerd him a-goin' on last night; him as the teetotal gentlemen from London sent daywn as our depytation. Lor', that were surprisin'!' The speaker was a dear old ranting preacher, a great friend of mine. 'Well, Tack, what did he say?' 'Say! Bless the Lord! he had 'em abaywt Timothy! "You tell me," ses he, "as Paul wrote that ther letter to Timothy, as Timothy was to take to wine bibbing. Nayw, let any man," ses he, "prove to me as Timothy minded what Paul said, and I 'll ha' no more pledges. Ah!" ses he; "I gnaw what Timothy did. He read that there letter, and he says, same as

I shud—What, me take to drinking? I ain't a-going to do it; not for a thaywsand Pauls, I ain't! Timothy war a man, he war,—he took that there letter, and he hull'd it away from him!'"

Medical Heroism.—Mr. Lawson Tait, in an address to the Wolverhampton Medical Society, said: "I have all through my professional life felt that those terms of praise about our craft, that it is honourable and self-sacrificing, are entirely deserved. I have even been able to feel many times that we deserved to rank as a noble profession, a term which has been ascribed to us by the highest authority. There are none who exercise the daily functions of medical practice but carry their lives in their hands, and we do it without the exciting aid of trumpet call and cannon smoke; we do it without the stimulus of the bubble ambition, or the speedy and almost painless death from a rifle ball. When we get a duty call from death we get it through the poisoned finger or the lingering pestilence, and we die in weary agony and without the hero's chaplet. Yet there is never a lack in filling the death vacancy. Day by day we are associated with poverty and misery and death, but most of us die in harness, battling to the end with the unhappiness of all around us, and with the poverty which is the lot of ninety per cent. of our profession."—*Edinburgh Medical Journal.*

The Attractions of Bath.—In an article headed "Music in Bath," the *Daily Telegraph* says: "'Welcome to Ba-ath, sir,' said Angelo Cyrus Bantam, Esquire, M.C., to the venerable president of the Pickwick Club, just then cast in damages for breach of promise. Bath has a welcome still; by no means confined to unsuccessful defendants. The Queen City of the West keeps its gates wide open, and would like to see many more enter than is the case in our degenerate day. It looks back with fond regret upon the glories of the past—glory attested by its stately streets, its noble squares, and aerial crescents; while deep down in the profoundest conviction of the beautiful place is an assurance that fortune will come back again laden with the good things of old. Why should it not? The healing waters pour forth in volume as great as when they made a new man of Prince Bladud, or as when the Roman conquerors of Britain constructed the baths, which to this day are stately even in ruin. Hot as ever, I believe, are the waters, and as greatly distinguished by the 'flavour of warm flat-irons,' which, according to Mr. John Smauker, signified the presence of 'killibeate.' The unrivalled position of the city is unrivalled still; its temperature remains as equable as of yore; Pump Room, Assembly Rooms, and Theatre Royal stand where they did; the supply of bath-chairs and Oliver's biscuits is equal to any demand; and, unless my information be altogether wrong, the throne of Beau Nash and Angelo Cyrus Bantam, Esquire, is occupied by an affable potentate who only regrets that more persons do not come and place themselves under his benign rule. Both as a social and sanatory institution, Bath is therefore no less 'fit' than heretofore. It resembles a mill running slowly, because having little to grind. Given more customers, and the machinery will work as merrily as ever. Fickle fashion may one day thus turn to its old love. Some, indeed, declare that there are signs even now of a change—that the Bath season is not a mere simulacrum, but a substantial entity, with promise in it of larger development as history more decidedly resolves to repeat itself in this particular regard. Of necessity the revival will have its differences, but human nature is a pretty constant quantity, and while the waters run, visitors may expect to meet Lord Mutanhed, the Honourable Mr. Crushton, the Dowager Lady Snuphanuph, Mrs. Colonel Wugsby, and other deathless types of social humanity. As far as music goes, Bath retains some of its old features."

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J. W. ARROWSMITH, PRINTER, QUAY STREET, BRISTOL.